2003

Effective January 1, 2003

Retiree Enrollment Guide

Understanding Your Medical and Dental Coverage

All necessary enrollment forms start on the back cover of this guide – see Appendix F first for instructions

Washington State Health Care Authority
Public Employees Benefits Board

HCA 51-205 (11/02)

Contact the Plans

For questions about a specific medical or dental plan, contact the Public Employees Benefits Board (PEBB) plans listed below. If you want additional information about PEBB coverage, call a benefits specialist toll-free at 1-800-200-1004, Monday through Friday, 8 a.m. to 5 p.m. (or visit our Web site at www.pebb.hca.wa.gov).

Medical Plans

	Web site address	Customer service phone numbers	TTY Customer service phone numbers (deaf, hard of hearing, or speech impaired)
Group Health Cooperative of Puget Sound	www.ghc.org	206-901-4636 or 1-888-901-4636	711 or 1-800-833-6388
Group Health Options, Inc.	www.ghc.org	206-901-4636 or 1-888-901-4636	711 or 1-800-833-6388
Kaiser Foundation Health Plan of the Northwest	www.kp.org/nw	1-800-813-2000 or Portland 503-813-2000	1-800-833-6388 (WA) 1-800-735-2900 (OR)
Medicare Supplement Plans E and J, administered by Premera Blue Cross	www.premera.com	Seattle/Everett: 425-670-5252 All other areas: 1-800-295-1841	1-800-291-4145
PacifiCare of Washington, Inc.	www.pacificare.com	1-800-932-3004	1-800-786-7387
Premera Blue Cross	www.premera.com	1-800-722-1471	1-800-842-5357
RegenceCare	www.wa.regence.com/pebb	1-800-376-7926	1-877-727-4357 or 206-389-6728
Uniform Medical Plan	www.ump.hca.wa.gov	425-670-3150 1-800-352-3968	1-888-923-5622

Medicare+Choice Plans

Group Health Cooperative	www.ghc.org	206-901-4636 or 1-888-901-4636	711 or 1-800-833-6388
Kaiser Senior Advantage	www.kp.org/nw	1-800-813-2000 or Portland 503-813-2000	1-800-833-6388 (WA) 1-800-735-2900 (OR)
PacifiCare Secure Horizons	www.securehorizons.com	Current members: 1-800-533-2743 Non-members: 1-800-647-7328	Current members: 1-800-786-7387 Non-members: 1-800-387-1074

Dental Plans

DeltaCare, administered by Washington Dental Service	www.deltadentalwa.com	1-800-650-1583
Regence BlueShield Columbia Dental Plan	www.wa.regence.com/pebb	1-800-376-7926
Uniform Dental Plan	www.deltadentalwa.com	1-800-537-3406

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Introduction

No two people have the same health care needs. And your own needs can change from year to year. The Public Employees Benefits Board (PEBB) program recognizes these differences by letting you choose the medical and dental plans that are best for you at the time of retirement. After you make that decision, you'll have the opportunity each year to consider the choices you made the year before and decide if they still meet your needs.

This guide provides answers to the questions most often asked by retirees. It is designed to educate you about your eligibility for continuing PEBB health care coverage, and to assist you in selecting a medical and/or dental plan that will meet your health care needs.

Inside this guide you will find:

- Commonly asked questions and their answers
- Descriptions of who's eligible
- An overview of your medical and dental coverage, including additional options if you are eligible for Medicare
- A chart which includes benefit information
- A summary of some of the differences between the plans
- A glossary defining unfamiliar terms

If you have questions that are not answered in this guide, call the Health Care Authority (HCA) at 1-800-200-1004, or the health plan in which you're interested.

Important!

The health plan comparisons in this document are based on information believed to be accurate and current, but be sure to confirm data before making decisions.

The benefits described in this book are brief summaries. For a complete description of your benefits, refer to the plan's certificate of coverage. You will receive your certificate of coverage directly from your plan after you enroll.

Some benefits described in this booklet are based on state laws. We have attempted to describe them accurately, but if there are differences, the laws will govern.

To obtain this publication in another format (such as Braille or audio), contact our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), please call 360-923-2701 or toll-free 1-888-923-5622.

Questions and Answers

Eligibility

1. **I recently retired; am I eligible for PEBB coverage?**
   See "Retiree Eligibility" on page 5.
2. **Are my family members eligible?**
   See "Dependent Eligibility" on page 6.
3. **If my spouse or qualified same-sex domestic partner is still working and I am enrolled under his or her employer-provided plan, do I have to enroll in PEBB retiree coverage?**
   No. If your spouse/qualified same-sex domestic partner is enrolled as an employee in a comprehensive employer-provided plan, you may continue coverage as a dependent. When your spouse/qualified same-sex domestic partner terminates employment, retires, dies, divorces, or the partnership dissolves, you are eligible to apply for PEBB retiree coverage within 60 days of that date. Please refer to "Waiving Coverage" on page 10 for additional information.
4. **If I return to work, am I still eligible for PEBB retiree coverage?**
   If you return to work and are eligible for employer-provided benefits, you may cancel your retiree coverage as soon as you are enrolled as an employee. When your employer-paid coverage ends, you must re-enroll in a PEBB retiree medical plan within 60 days of the date the other coverage ends. Please refer to "Waiving Coverage" on page 10 for additional information.
5. **If I die, can my surviving dependents continue PEBB coverage?**
   See "Dependent Eligibility" on page 6.
6. **If I choose not to enroll in a PEBB plan within 60 days of retirement, will I be allowed to enroll at a future time?**
   See "Enrollment at Retirement" on page 8.
7. **If I am temporarily not in pay status because I am applying for disability retirement, can I continue PEBB coverage?**
   See "Enrollment at Retirement" on page 8.
8. **If my family members become ineligible for coverage (i.e., my spouse and I divorce), can they continue PEBB coverage?**
   Your affected dependents have the right to continue coverage up to 36 months by self-paying premiums if any of the following circumstances occur:
   - If you and your spouse divorce (and your spouse is not a state employee)
   - Your same-sex domestic partner no longer qualifies for PEBB coverage
   - Your child ceases to be a dependent under PEBB eligibility rules

   Application for continuation of coverage under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) must be made to the HCA within 60 days after the date the dependent's coverage would otherwise end.

Medicare

9. **What if I am eligible for Medicare?**
   See "Medicare Eligibility" on page 7.

Selecting a Plan

10. **What medical plans are available?**
    See "Plans Available by County" on pages 14-20.
11. **How do the medical plans differ?**
    See the "Medical Benefits Comparison" chart in Appendix A.
12. **How do I select the best medical plan for my family?**
    See "Selecting the Best Plan for You and Your Family" in Appendix A.
13. **May I add dental coverage?**
    You may enroll in a dental plan during any open enrollment period, but you must maintain dental coverage **for at least two years.**
14. **Can I enroll *only* in PEBB dental coverage?**
    No, to enroll in dental coverage, you must enroll in PEBB medical coverage.
15. **If my dependents or I waived PEBB medical coverage during my active employment, can I enroll in PEBB retiree medical coverage when I retire?**
    See "Enrollment at Retirement" on page 8.

Even if your doctor, dentist, or health care facility discontinues participation in your plan, you may not change plans until the next open enrollment period.

Providers

16. **How do I know if my provider or hospital belongs to a plan?**
    Call the plan or your provider directly. For medical or dental plans, refer to the telephone numbers listed at the front of this booklet. When you call the plan, be sure to mention that you are a PEBB state of Washington retiree. Chances are that your doctor or hospital participates in one or more of the PEBB plans. You may also search for providers, hospitals, and pharmacies that contract with the medical plan you're interested in at the online Provider Directory at www.pebb.hca.wa.gov.
17. **May I change providers after I have joined a managed care plan?**
    Yes, although rules vary from plan to plan. Call your plan directly for details.
18. **Do all my family members have to use the same provider?**
    They can select the same provider, but it's not required. Each member of your family may select his or her own provider available through the plan.
19. **If I want the freedom to see any doctor or health care provider without a primary care provider referral, which plan should I enroll in?**
    The Uniform Medical Plan (UMP) allows freedom of choice for all approved provider types. Group Health Options allows you to self-refer to extended network providers for certain benefits. However, your out-of-pocket expenses may be higher. Call the plans for details.

Questions and Answers

Cost

20. How much do the plans cost?
Please refer to the rate sheet in the back of this guide. In addition to your monthly premiums, you will be responsible for any plan deductibles, coinsurance, or copayments under the provisions of the plan you choose. See the certificates of coverage available from each plan for detailed information.

Medicare-eligible retirees who are enrolled in both Parts A and B of Medicare may receive a lower "Medicare-eligible" premium in all PEBB medical plans. The lower rate is possible because those enrolled in both Parts A and B will receive primary benefits from Medicare, leaving less for the PEBB-sponsored plan to pay. If both a retiree and his or her spouse/qualified same-sex domestic partner are Medicare-eligible, their total monthly premium may be even lower.

21. How do I pay for coverage?
You pay for PEBB medical or dental coverage through pension deductions, direct payment to the HCA, automatic bank account withdrawals, or if you participate in Volunteer Employee Benefit Association (VEBA), premiums can be paid by your VEBA account.
If you pay for your coverage through pension deductions, the premium deduction taken from your end-of-the-month pension check is for that same month's coverage. For example, if your coverage takes effect January 1, your January 31 check will reflect your premium deduction for January coverage.

22. If my spouse/qualified same-sex domestic partner or I die in the middle of a month, do I have to pay the full month's premium?
Yes. Premiums are charged and collected for the full month and cannot be prorated.

Changing Your Plans

23. When may I change plans?
See page 9.

Retiree Eligibility

Retired or permanently disabled employees of state government, higher education, K-12 school districts, educational service districts, and participating employer groups are eligible for coverage in the PEBB plans on a self-pay basis in accordance with WAC 182-12-117. In order to be eligible, the following conditions must be met:

- If you are vested under one of the following state of Washington retirement systems, you must immediately receive a monthly retirement allowance, or have taken a lump-sum payment because your monthly benefit would be less than $50:
  - Public Employees Retirement System (PERS 1, 2, or 3), with the exception noted in the next column
  - Teachers' Retirement System (e.g., TRS 1, 2, or 3), with the exception noted in the next column
  - Higher Education Retirement Plan (e.g., TIAA-CREF), with the exception noted in the next column
  - Law Enforcement Officers' and Fire Fighters' Retirement System (LEOFF 1 or 2)
  - State Judges/Judicial Retirement System
  - Washington State Patrol Retirement System (WSPRS Plan 1 or 2)
  - Washington School Employees Retirement System (SERS 2 or 3), with the exception noted in the next column
- If you are vested in Public Employees Retirement System (PERS) 3, Teachers Retirement System (TRS) 3, and Washington School Employees Retirement System (SERS) 3 and not receiving a monthly retirement allowance (defined benefit): You must be at least age 55 with at least 10 years of service credit at the time of separation.
- If you are vested in a Washington State Higher Education Retirement Plan (e.g., TIAA-CREF): You must be at least age 55 with at least 10 years of service, or at least age 62, or must immediately begin receiving a monthly retirement benefit.
- If you are an employee who is permanently disabled, you are eligible for coverage if you are eligible for a deferred monthly retirement income benefit and you apply for retiree coverage before your active employment ends.
- All retirees must submit an application to enroll in or waive retiree medical coverage no later than 60 days after active employment ends or their continuous COBRA coverage ends. Retirees may enroll in a PEBB dental plan at that time or during any PEBB open enrollment period as long as the enrollee has PEBB medical coverage. **Please note:** If you are interested in waiving your retiree coverage, see "Enrollment at Retirement" on page 8.

Retirees and permanently disabled employees of employer groups whose participation in a PEBB plan ends may be eligible to continue PEBB retiree coverage for an 18-month period as authorized by the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

Appointed and elected officials of the legislative and executive branches of state government who

leave public office may continue their PEBB medical coverage or medical/dental coverage on a self-pay basis whether or not they receive a retirement benefit from a state retirement system provided they apply no later than 60 days after the end of their term.

- If you are a Medicare-eligible retiree, you must enroll in Medicare Parts A and B.

Dependent Eligibility

If you are enrolled in a medical or medical/dental plan, you may also enroll the following dependents in the same plan(s):

- Your lawful spouse or qualified same-sex domestic partner.
- Your children through age 19. The term "children" includes your natural children, stepchildren, legally adopted children, children for whom you have assumed a legal obligation for total or partial support in anticipation of adoption of the child, children of the qualified same-sex domestic partner, or children specified in a court order or divorce decree. Married children who qualify as your dependents under the Internal Revenue Code and additional legal dependents approved by the HCA are included. Children who are full-time students or who are developmentally or physically disabled are eligible beyond age 19 under the following conditions:
  - Students age 20 through age 23 are eligible if they are: (i) dependent on you for maintenance and support, and (ii) are registered and attend full-time an accredited secondary school, college, university, vocational school, or school of nursing. Coverage of dependent students continues year-round for those who attend three of the four school quarters and for three full calendar months following graduation as long as you are covered at the same time. The HCA will verify student eligibility annually.
  - Children of any age are eligible if they are incapable of self-support due to a developmental disability or physical handicap, provided that their condition occurred before age 20, or during the time they were covered under a PEBB plan as a full-time student. Proof of such disability and dependency must be provided to the HCA upon application and as periodically requested thereafter.
- Your surviving dependents who are covered at the time of your death may continue their coverage on a self-pay basis. Your spouse's/qualified same-sex domestic partner's PEBB coverage will continue indefinitely as long as premiums are paid. Other family members may continue coverage until they are no longer eligible under PEBB rules as stated above. Surviving dependents must apply to enroll in PEBB coverage or waive the coverage while enrolled in comprehensive, employer-provided coverage within 60 days from the date of your death.

Adding Dependents

Dependents must be enrolled within 31 days of eligibility, except in the following situations:

- Newborn natural or adopted children, or children of a qualified same-sex domestic partner, must be enrolled within 60 days of eligibility if addition of the new family member increases your monthly premium.

  When the child(ren) becomes eligible before the 16th day of the month, the new full month's premium is charged; otherwise, the new premium will begin with the next full calendar month. Contact the Health Care Authority or the benefits office of your higher-education institution for an enrollment form.

- Dependents who lose other medical coverage must enroll in a PEBB plan within 60 days of the date their other coverage ends. Dependents will be required to provide proof of continuous, comprehensive medical coverage up to the time their other coverage terminates. If the dependent meets enrollment criteria and premiums are paid, PEBB-sponsored coverage will begin the first day of the month after the other coverage is terminated.
- During the annual open enrollment period. This occurs each fall, and coverage for the dependent would begin on January 1 of the following year.

If you cover eligible dependents, they must be covered under the same medical and dental plans you choose. See "Medicare Eligibility" below if you or one of your family members are eligible for Medicare.

Medicare Supplement Rates

The "Outline of Medicare Supplement Coverage," in Appendix C, is for the 2002 calendar year.

In addition, cost-sharing amounts shown in this Medicare supplement coverage outline are also expected to change in order to coincide with any changes in the applicable Medicare deductible amount and copayments. An updated "Outline of Medicare Supplement Coverage" will be sent to persons enrolling in the plan.

Medicare Eligibility

Prior to becoming eligible for Medicare, you should contact your nearest Social Security Office to inquire about Medicare enrollment. When you or any covered family members receive your Medicare card, send a copy of it to the HCA. Your premium will then be adjusted to reflect the Medicare rate.

If you are eligible for Medicare when you retire, you must enroll in both Parts A and B of Medicare in order to continue enrollment in PEBB plans. In most cases, Medicare will be the primary coverage and the PEBB-sponsored medical plan will be secondary.

The PEBB offers a variety of plan choices to Medicare-eligible enrollees. You may continue enrollment in your current PEBB-sponsored plan

(standard managed-care plan*, extended network managed-care plan, or the Uniform Medical Plan), or you can enroll in either one of the three Medicare+Choice plans or Medicare Supplement Plan E or Plan J, administered by Premera Blue Cross. You can enroll in one of the Medicare supplement plans within six months of becoming eligible for Parts A and B of Medicare or during an annual open enrollment.

If you cover eligible family members, they must be enrolled in the same medical and dental plans you choose. If you and your spouse/qualified same-sex domestic partner are both on Medicare Parts A and B, you must enroll in the same plan. **However, if the retiree or spouse/qualified same-sex domestic partner is eligible to enroll in a Medicare supplement plan and chooses Plan E or J, all other eligible family members must enroll in the Uniform Medical Plan.** If you or your spouse/qualified same-sex domestic partner are on Medicare disability, you may enroll in a Medicare supplement plan; however, Medicare-eligible dependent children are not eligible to enroll in Medicare supplement plans.

Clarification for Medicare-enrolled retirees: Many Medicare-eligible retirees think they can only enroll in a Medicare supplement plan. THIS IS NOT TRUE. All of the PEBB plans offered to employees are also offered to all retirees, including retirees who are Medicare-eligible. The PEBB also offers Medicare Supplement Plans E and J through Premera Blue Cross. The Medicare supplement plans are designed to pay some of the Medicare deductibles and coinsurances, but primarily supplement only those services that are covered by Medicare.

Enrollment at Retirement

You must return your completed enrollment form within 60 days of the date your employment ends to receive or waive coverage. **Please note**: If you or your dependents waived medical coverage during your employment, you can enroll in or waive PEBB retiree coverage within 60 days of the date your employment ends. You may want to complete your enrollment form when you file your application for retirement benefits. If you choose to enroll in retiree coverage, your coverage will be retroactive to the date your employee coverage ends.

If you don't enroll in or waive coverage within the 60-day period, you forfeit all further rights to enroll in the PEBB program.

Don't forget, you must enroll in Medicare Parts A and B (if you're eligible) before you enroll in PEBB coverage.

If you are temporarily not in pay status because you are applying for disability retirement, you may continue group PEBB coverage by self-paying the premium for medical coverage only, or for medical and dental coverage combined, and/or for retiree term life insurance.

** In most areas, if you are enrolled in Group Health Cooperative, Kaiser Permanente, or PacifiCare when you become Medicare-eligible, you will be required to enroll in their Medicare+Choice plan. See the "Plans Available by County" section.*

Enrolling is Easy. Follow These Steps:

1. Read this guide.
2. Check to see which medical plans are offered in your area. (See the "Plans Available by County" section beginning on page 14.)
3. Gather information.
   a) Read about the medical and dental plans that interest you. (Review the "Medical Benefits Comparison" chart in Appendix A and the dental plans section beginning on page 27.)
   b) Find out the health plans' monthly premiums. You can find a rate sheet in the back of this guide.
   c) Call the plans to request a list of their providers or ask questions. (Plan phone numbers and Web site addresses are listed on the inside front cover.) You can also find out if your provider participates with the medical plan you choose by checking the Provider Directory on the HCA Web site at www.pebb.hca.wa.gov. If you are choosing a doctor or other provider for the first time, be sure to find out if he or she is accepting new patients.
   d) Talk to a benefits specialist at the Health Care Authority, or an insurance specialist at your institution of higher education.
4. Choose your medical/dental plan.
5. Review "Completing the Medical and Dental Coverage Forms" in Appendix F for instructions on filling out and returning the enrollment form(s).

Please note: If you or any covered dependents are eligible for Medicare, please include a copy of the Medicare card with your enrollment form(s).

Changing Your Plans

Your coverage remains in effect for an entire year (January 1 through December 31). However, you may be able to change plans during the plan year in the following situations:

- If you move you may change your plan enrollment within 31 days of your move under the following conditions: if you move from your plan's service area, you may enroll in any plan available in your new locality, or if a plan has not been available to you and you move into that plan's service area, you may enroll in that plan. All such plan enrollment changes take effect on the first day of the month following the date you move.
- If a court order requires you to provide medical coverage for an eligible spouse, same-sex domestic partner, or child, you may change medical plans and add the family member, with the change effective the first of the month after the HCA receives a completed application, including all necessary supporting documentation.

- When you retire you may change plans at the time you apply for retiree coverage. The change is effective the same day that retiree coverage takes effect.
- During the annual open enrollment period. This usually occurs each fall, and your coverage under the new plan would begin on January 1 of the following year.
- You may choose to enroll in Medicare Supplement Plans E or J, administered by Premera Blue Cross, within six months of becoming eligible for Medicare.

When Coverage Ends

Your PEBB retiree coverage ends on the last day of the month in which you stop paying premiums. Coverage for your spouse/qualified same-sex domestic partner or other dependents ends on the last day of the month in which the family members cease to be eligible under PEBB rules.

If you or a covered family member is confined in a hospital or other medical facility when your coverage ends, contact the HCA within 31 days to determine whether you or they are eligible for an extended benefit.

If you cancel your PEBB retiree coverage, you will not be allowed to enroll again later, except as outlined in "Waiving Coverage."

Waiving Coverage

You may waive PEBB medical and dental coverage for yourself and your dependents if you are covered under another comprehensive, employer-provided benefits package. (Other coverage may be attained through your re-employment or your spouse's/qualified same-sex domestic partner's employment.) When the employer coverage ends, you may enroll in PEBB medical and dental coverage with evidence of continuous coverage. Application must be made within 60 days of losing the other coverage. (In order to continue retiree life coverage, you must select it upon retirement and premiums must continue to be paid while you're re-employed.)

Identification Cards

After you enroll, you'll receive an identification card from your plan. Show this card to your providers when you receive care. If you have any questions about your identification card, contact your plan directly. **Please note:** The Uniform Dental Plan does not issue identification cards.

How the Medical Plans Work

There are five types of plans available to PEBB retirees. **Please note:** Not all types of plans are available in every county. Refer to the "Plans Available by County" section to find out which plans are available in your area.

- **Standard managed-care plans:** These plans are available to all retirees except those Medicare-eligible retirees enrolled in Group Health Cooperative, Kaiser Permanente, and PacifiCare. These three medical plans require Medicare-eligible retirees to enroll in their Medicare+Choice plan if they offer both a standard and Medicare+Choice plan in the same county.

  Standard plans have a $10 copay for many services, and help cover the deductible and coinsurance not covered by Medicare. Urgent or emergency care is covered even if you receive care outside of your health plan's service area.

  Important!
  If your doctor leaves the plan before the next open enrollment, you are **not allowed** to change plans. Keep this in mind when choosing a medical plan.

  Most standard managed-care plans require you to choose a primary care provider (PCP) available through that plan. For most plans, if you go to a specialist without a referral from your PCP, you may be responsible for the total charges if you are not Medicare-eligible, or for charges not paid by Medicare if you are Medicare-eligible.

  (**Please note:** *Premera Blue Cross* does not require selection of a PCP, and allows members to self-refer to network providers, including specialists.)

- **Extended network managed-care plan:** This type of plan has network and extended network benefits. If you self-refer to a provider in the extended network rather than being referred by your PCP, the plan will still pay benefits, but at a lower level than if you followed the standard managed-care network guidelines and referral process.

  Some extended network benefits require payment of an annual deductible and copayment and/or coinsurance before the plan pays benefits. Then reimbursement is usually between 60 and 70 percent of allowed charges. Some benefits are not covered under the extended network. Contact the plan for specific extended network benefits.

  Urgent or emergency care is also covered if you receive services outside of Washington.

- **Medicare+Choice plans:** These plans are additional options only available to Medicare-eligible retirees through Group Health Cooperative, Kaiser Permanente, and PacifiCare. If these medical plans offer both a standard and Medicare+Choice plan in the same county and you are Medicare-eligible, they will require you to enroll in the Medicare+Choice plan.

  Medicare+Choice plans contract with Medicare to provide all benefits covered by Medicare; however, most also cover the Medicare deductibles, coinsurance, and additional benefits not covered by Medicare.

Generally speaking, the Medicare+Choice benefits are comparable or superior to managed-care plan benefits. Please refer to each Medicare+Choice plan's certificate of coverage or call the plans if you have specific benefit questions.

When you join a Medicare+Choice plan, you receive your health care from the plan's network of medical providers, hospitals, and pharmacies. These plans are more affordable; however, certain restrictions apply. If your PCP does not provide or coordinate all of your care, and if you do not follow all of the managed care procedures, you could be responsible for the entire bill.

- **Preferred provider organization (PPO):** The UMP is available to all PEBB retirees worldwide. This state-administered, self-insured plan offers retirees the freedom to choose any approved provider type. It is also available to those who travel or live outside the state of Washington. You may receive services from any approved provider type, but reimbursement is higher if services are provided by a UMP network provider or, if you are Medicare-eligible, by a doctor or nurse who accepts Medicare assignment.

  Most services are subject to an annual deductible. See the UMP certificate of coverage for details.

- **Medicare Supplement Plans E and J:** These plans are only available to Medicare-eligible retirees enrolled in Medicare Parts A and B. These plans allow the use of any Medicare-recognized physician or hospital nationwide. They are designed to pay some Medicare deductibles and coinsurances, but primarily supplement only those services that are covered by Medicare. Benefits such as vision, hearing exams, routine physical exams, and prescription drugs may have limited coverage or may not be covered at all.

Coordination of Benefits

All PEBB plans use some form of "coordination of benefits" (COB) to coordinate benefit payments with other group plans, Medicaid, Medicare, and Workers' Compensation. These COB provisions ensure that benefit costs are more fairly distributed when a person is covered by more than one plan. This typically occurs when you and your spouse or qualified same-sex domestic partner are both covered by group plans and/or Medicare, and your dependent(s) are covered under both plans. The COB provisions depend on whether you are eligible for Medicare and which plan you join. (PEBB plans will not reduce benefits for any individual medical or dental insurance policy you purchased for yourself or family members.)

If You Are Eligible for Medicare

Standard and extended network managed-care plans: Each of the managed-care plans provides comprehensive coverage for Medicare-eligible retirees, comparable to coverage that is offered to employees. In most cases, the Medicare deductible and coinsurance are covered when you are enrolled in a standard managed-care plan.

Uniform Medical Plan: For retirees enrolled in Medicare, the UMP is always secondary to Medicare. Benefits are coordinated with Medicare up to 100 percent of the UMP's allowed charges once the annual deductibles have been met. For services covered by the UMP

and not covered by Medicare, UMP will be the primary payer and pay normal UMP benefits. See the UMP Certificate of Coverage or call the UMP for details.

Medicare+Choice plans: Group Health Cooperative Medicare managed-care plan, Kaiser Senior Advantage, and PacifiCare Secure Horizons are Medicare+Choice plans. These plans provide the full scope of Medicare benefits combined with PEBB benefits, but because they vary from plan to plan, refer to the plans' certificates of coverage (available from the plans) for details. Although these plans are usually less expensive than standard managed-care plans, neither the plan nor Medicare will pay for services received outside of the plan's network except for authorized referrals and emergency care.

Medicare supplement plans: If you or your spouse/qualified same-sex domestic partner are enrolled in Medicare Parts A and B, you have a choice of two Medicare supplement plans, Plan E and Plan J, in addition to the other medical plans described in this guide. Plans E and J are designed to supplement your Medicare coverage by reducing your out-of-pocket expenses and providing additional benefits. They each pay some Medicare deductible and coinsurance expenses. For example, Plan E pays the Medicare Part A deductible and provides some coverage for routine examinations. Plan J covers those same services in addition to the Part B deductible and a limited prescription drug benefit. See the "Outline of Medicare Supplement Coverage" section in this guide.

Medical Plans

Plans Available by County – Washington

Adams
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Asotin
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Benton
- Group Health Cooperative
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Chelan
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Clallam
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

Clark
- Kaiser Permanente
- Kaiser Senior Advantage (Medicare+Choice)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- PacifiCare
- PacifiCare Secure Horizons (Medicare+Choice)
- Uniform Medical Plan

Columbia
- Group Health Cooperative
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Cowlitz
- Kaiser Permanente
- Kaiser Senior Advantage (Medicare+Choice)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Douglas
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Ferry
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Franklin
- Group Health Cooperative
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Garfield
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Grant
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Grays Harbor
- Group Health Cooperative (ZIP Codes 98541, 98557, 98559, and 98568)
- Group Health Cooperative (Medicare+Choice; ZIP Codes 98541, 98557, 98559, and 98568)
- Group Health Options (ZIP Codes 98541, 98557, 98559, and 98568)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- PacifiCare (ZIP Codes 98541 and 98557)
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

Island
- Group Health Cooperative
- Group Health Cooperative (Medicare+Choice)
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Jefferson
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

King
- Group Health Cooperative
- Group Health Cooperative (Medicare+Choice)
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- PacifiCare
- PacifiCare Secure Horizons (Medicare+Choice)
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

Kitsap
- Group Health Cooperative
- Group Health Cooperative (Medicare+Choice)
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

Kittitas
- Group Health Cooperative
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Klickitat
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Lewis
- Group Health Cooperative
- Group Health Cooperative (Medicare+Choice)
- Group Health Options
- Kaiser Permanente (ZIP Codes 98591, 98593, and 98596)
- Kaiser Senior Advantage (Medicare+Choice; ZIP Codes 98591, 98593, and 98596)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- PacifiCare
- PacifiCare Secure Horizons (Medicare+Choice)
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Medical Plans

Lincoln
- Group Health Cooperative (ZIP Codes 99008, 99029, 99032, and 99122)
- Group Health Options (ZIP Codes 99008, 99029, 99032, and 99122)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Mason
- Group Health Cooperative
- Group Health Cooperative (Medicare+Choice)
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- PacifiCare (ZIP Code 98584)
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

Okanogan
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Pacific
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

Pend Oreille
- Group Health Cooperative (ZIP Code 99009)
- Group Health Options (ZIP Code 99009)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Pierce
- Group Health Cooperative
- Group Health Cooperative (Medicare+Choice)
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- PacifiCare
- PacifiCare Secure Horizons (Medicare+Choice)
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

San Juan
- Group Health Cooperative
- Group Health Cooperative (Medicare+Choice)
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Skagit
- Group Health Cooperative
- Group Health Cooperative (Medicare+Choice)
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

Skamania
- Kaiser Permanente (ZIP Codes 98639 and 98648)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Snohomish
- Group Health Cooperative
- Group Health Cooperative (Medicare+Choice)
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- PacifiCare
- PacifiCare Secure Horizons (Medicare+Choice)
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

Spokane
- Group Health Cooperative
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Stevens
- Group Health Cooperative (ZIP Codes 99006, 99013, 99026, 99034, 99040, 99110, 99148, and 99173)
- Group Health Options (ZIP Codes 99006, 99013, 99026, 99034, 99040, 99110, 99148, and 99173)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Thurston
- Group Health Cooperative
- Group Health Cooperative (Medicare+Choice)
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- PacifiCare
- PacifiCare Secure Horizons (Medicare+Choice)
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Wahkiakum
- Kaiser Permanente (ZIP Codes 98612 and 98647)
- Kaiser Senior Advantage (Medicare+Choice; ZIP Codes 98612 and 98647)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Walla Walla
- Group Health Cooperative
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Whatcom
- Group Health Cooperative
- Group Health Cooperative (Medicare+Choice)
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Whitman
- Group Health Cooperative
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Yakima
- Group Health Cooperative
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Plans Available by County – Oregon

Benton
- Kaiser Permanente (ZIP Codes 97330-31, 97333, 97339, 97353, and 97370)
- Kaiser Senior Advantage (Medicare+Choice; ZIP Codes 97330-31, 97333, 97339, 97353, and 97370)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- PacifiCare
- PacifiCare Secure Horizons (Medicare+Choice)
- Uniform Medical Plan

Clackamas
- Kaiser Permanente (ZIP Codes 97004, 97009, 97011, 97013, 97015, 97017, 97022-23, 97027, 97034-36, 97038, 97042, 97045, 97049, 97055, 97067-68, 97070, 97222, and 97267-68)
- Kaiser Senior Advantage (Medicare+Choice; ZIP Codes 97004, 97009, 97011, 97013, 97015, 97017, 97022-23, 97027, 97034-36, 97038, 97042, 97045, 97055, 97067-68, 97070, 97222, and 97267-68)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- PacifiCare
- PacifiCare Secure Horizons (Medicare+Choice)
- Premera Blue Cross/Foundation (ZIP Codes 97034-35 and 97045)
- Uniform Medical Plan

Columbia
- Kaiser Permanente
- Kaiser Senior Advantage (Medicare+Choice)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- PacifiCare
- Uniform Medical Plan

Hood River
- Kaiser Permanente (ZIP Code 97014)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation (ZIP Code 97031)
- Uniform Medical Plan

Lane
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- PacifiCare
- PacifiCare Secure Horizons (Medicare+Choice)
- Uniform Medical Plan

Linn
- Kaiser Permanente (ZIP Codes 97321-22, 97335, 97355, 97358, 97360, 97374, and 97389)
- Kaiser Senior Advantage (Medicare+Choice; ZIP Codes 97321-22, 97335, 97355, 97358, 97360, 97374, and 97389)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- PacifiCare
- PacifiCare Secure Horizons (Medicare+Choice)
- Uniform Medical Plan

Marion
- Kaiser Permanente (ZIP Codes 97002, 97020, 97026, 97032, 97071, 97137, 97301-03, 97305-14, 97325, 97342, 97346, 97352, 97359, 97362, 97373, 97375, 97381, 97383-85, and 97392)
- Kaiser Senior Advantage (Medicare+Choice; ZIP Codes 97002, 97020, 97026, 97032, 97071, 97137, 97301-03, 97305-14, 97325, 97352, 97359, 97362, 97375, 97381, 98383-85, and 97392)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- PacifiCare
- PacifiCare Secure Horizons (Medicare+Choice)
- Uniform Medical Plan

Multnomah
- Kaiser Permanente
- Kaiser Senior Advantage (Medicare+Choice)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- PacifiCare
- PacifiCare Secure Horizons (Medicare+Choice)
- Premera Blue Cross/Foundation (ZIP Codes 97030, 97080, 97201-21, 97227-28, 97230-33, 97236, 97238, 97240, 97242, 97251, 97253-56, 97258-59, 97266, 97271-72, 97280, 97282-83, 97286, 97290, 97292-94, 97296, and 97299)
- Uniform Medical Plan

Polk
- Kaiser Permanente
- Kaiser Senior Advantage (Medicare+Choice)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- PacifiCare
- PacifiCare Secure Horizons (Medicare+Choice)
- Uniform Medical Plan

Umatilla
- Group Health Cooperative (ZIP Codes 97810, 97813, 97835, 97862, 97882, and 97886)
- Group Health Options (ZIP Codes 97810, 97813, 97835, 97862, 97882, and 97886)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation (ZIP Codes 97801, 97810, 97813, 97859, 97862, and 97886)
- Uniform Medical Plan

Washington
- Kaiser Permanente
- Kaiser Senior Advantage (Medicare+Choice)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- PacifiCare
- PacifiCare Secure Horizons (Medicare+Choice)
- Premera Blue Cross/Foundation (ZIP Codes 97005-08, 97075-76, 97116, and 97123-24)
- Uniform Medical Plan

Yamhill
- Kaiser Permanente
- Kaiser Senior Advantage (Medicare+Choice)
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- PacifiCare
- Uniform Medical Plan

Plans Available by County – Idaho

Benewah
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation (ZIP Codes 83824, 83851, 83861, and 83870)
- Uniform Medical Plan

Bonner
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation (ZIP Codes 83804, 83809, 83813, 83821-22, 83825, 83840-41, 83848, 83852, 83856, 83860, 83862, and 83864-65)
- Uniform Medical Plan

Kootenai
- Group Health Cooperative
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Latah
- Group Health Cooperative
- Group Health Options
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Nez Perce
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation (ZIP Codes 83501, 83524, 83540, 83541, and 83551)
- Uniform Medical Plan

Shoshone
- Medicare Supplement Plan E
- Medicare Supplement Plan J
- Premera Blue Cross/Foundation (ZIP Codes 83839, 83850, and 83868)
- Uniform Medical Plan

General Medical Exclusions

Managed Care Plans

The following services and supplies are excluded from all PEBB-sponsored managed care plans. Plan-specific exceptions are noted. For further explanation of any exclusion, refer to the plan's certificate of coverage.

1. Services not provided by a plan-designated provider or obtained in accordance with the plan's standard referral and authorization requirements, except for emergency care or as covered under coordination of benefits provisions. (Does not apply to Group Health Options, Inc.).
2. Services rendered outside the service area when the need for care could have been reasonably foreseen by the enrollee before leaving the service area, unless preauthorized by the plan. (Does not apply to Group Health Options, Inc.)
3. Experimental or investigational services, supplies, and drugs.
4. That additional portion of a physical exam beyond a routine physical that is specifically required for the purpose of employment, travel, immigration, licensing, or insurance and related reports.
5. Services or supplies for which no charge is made, or for which a charge would not have been made if the enrollee had no health care coverage or for which the enrollee is not liable; services provided by a family member.
6. Drugs and medicines not prescribed by a plan-designated provider, except for emergency treatment. (Does not apply to Group Health Options, Inc.)
7. Cosmetic services or supplies except: to restore function, for reconstructive surgery of a congenital anomaly, or reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
8. Skilled nursing facility confinement or residential mental health treatment programs for mental health conditions, mental retardation, or for care which is primarily domiciliary, convalescent, or custodial in nature.
9. Conditions caused by or arising from acts of war.
10. Dental care including orthognathic surgery, nonsurgical treatment of temporomandibular joint (TMJ) dysfunction and myofascial pain dysfunction (MPD), and dental implants.
11. Sexual reassignment surgery, services, and supplies.
12. Reversal of voluntary sterilization.
13. Testing and treatment of infertility and sterility, including but not limited to artificial insemination and in vitro fertilization.
14. Services and supplies provided solely for the comfort of the enrollee, except palliative care provided under the "Hospice Care" benefit.
15. Coverage for an organ donor, unless the recipient is an enrollee of this plan.
16. Medical services, drugs, supplies or surgery (such as but not limited to gastroplasty, gastric stapling, or intestinal bypass) directly related to the treatment of obesity.
17. Evaluation and treatment of learning disabilities, including dyslexia, except as provided for neurodevelopmental therapies.

18. Orthoptic therapy (eye training); vision services, except as specified for vision care. Surgery to improve the refractive character of the cornea including any direct complications.
19. Orthotics, except foot care appliances for prevention of complications associated with diabetes which are covered.
20. Routine foot care.
21. Services for which an enrollee has contractual right to recover cost under homeowner's or other no-fault coverage, to the extent that it can be determined that the enrollee received double recovery for such services.
22. Charges for missed appointments or for failure to provide timely notice for cancellation of appointments; charges for completing or copying forms or records.
23. Any medical services or supplies not specifically listed as covered.
24. Direct complications arising from excluded services.
25. Pharmaceutical treatment of impotence.
26. When Medicare coverage is primary, charges for services or supplies provided to enrollees through a "Private Contract" agreement with a physician or practitioner who does not provide services through the Medicare program.
27. Replacement of lost or stolen medications.
28. Recreation therapy.

Uniform Medical Plan (UMP)

The following is an **abbreviated** list of exclusions for the UMP. The UMP does not cover any of the following, nor can such charges be applied to any required plan deductible or out-of-pocket limit.

In addition to any exclusions and maximums/limits mentioned in the *2003 Certificate of Coverage*, the UMP does not cover:

1. Acupuncture, except as described under "Acupuncture" in "Covered Expenses."
2. Additional portion of a physical exam beyond what is covered by the preventive care benefit, such as that required for employment, travel, immigration, licensing, or insurance and related reports.
3. Alcohol/drug information or referral services or enrollment in Alcoholics Anonymous or similar programs such as services provided by schools or emergency service patrol.
4. Air ambulance, if ground ambulance would serve the same purpose, or transportation by "cabulance" or other nonemergency service.
5. Any services or supplies not specifically listed as covered.
6. Autologous blood and its derivatives, including extraction or storage except when used for a covered peripheral stem cell rescue procedure.
7. Circumcision, unless determined medically necessary for a medical condition.
8. Complications directly arising from services not covered.
9. Conditions caused by or arising from acts of war.

10. Convalescent or custodial care (intended primarily to assist in activities of daily living and not requiring continued services of skilled medical or allied health professionals).
11. Cosmetic services or supplies except for:
    - Reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
    - Reconstructive surgery of a congenital anomaly.
    - Restoring function.
12. Court-ordered care, unless determined by UMP to be medically necessary and otherwise within the UMP's coverage criteria.
13. Dental care other than the specific covered dental services listed in the *2003 Certificate of Coverage*. For example, the following are not covered:
    - Any treatment of caries or gum disease (including, but not limited to, extractions or aveoplasties), or other dental-specific services, regardless of the cause.
    - Dental implants.
    - Malocclusion resulting from accidental injury.
    - Nonsurgical treatment of temporomandibular joint (TMJ) dysfunction or myofascial pain dysfunction.
    - Orthodontic treatment.
    - Orthognathic surgery.
    - Treatment of injuries caused by biting or chewing.
    - Nitrous oxide.
14. Drugs or medicines not prescribed by an approved provider type, or not requiring a prescription, except as listed in exclusion 40.
15. Educational programs, such as nutritional counseling for cholesterol control, or lifestyle modification programs, except as described under "Diabetes Education" and "Tobacco Cessation Program."
16. Electron Beam Tomography (EBT), self-referred or prescribed by a provider.
17. Equipment such as:
    - Air conditioners or air purifying systems.
    - Arch supports.
    - Corrective shoes (except for diabetes).
    - Convenience items/options.
    - Exercise equipment.
    - Sanitary supplies.
    - Special or extra-cost features.
18. Experimental or investigational services, supplies, or drugs.
19. Food supplements (other than for PKU), such as infant or adult dietary formulas.
20. Foot care routine procedures, treatment of corns and calluses, corrective shoes, treatment of fallen arches or symptomatic complaints of the feet, orthotics, or related prescriptions. (Foot care appliances for prevention or treatment of diabetes complications, however, are covered.)
21. Hearing care services or supplies such as:
    - A hearing aid that exceeds specifications prescribed for correction of hearing loss.
    - Charges incurred after plan coverage ends, unless the hearing aid was ordered before that date and is delivered within 45 days after UMP coverage ends.

- Purchase of batteries or other ancillary equipment, except those covered under terms of the initial hearing aid purchase.

22. Home health care such as:
    - 24-hour or full-time care in the home, unless preauthorized.
    - Any services or supplies not included in the home health care treatment plan or not specifically mentioned under "Covered Expenses."
    - Dietary assistance.
    - Homemaker, chore worker, or housekeeping services.
    - Maintenance or custodial care.
    - Medically unnecessary services.
    - Nonclinical social services.
    - Psychiatric care.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Supportive environmental materials/ improvements (handrails, ramps, etc.).
    - Visits exceeding two hours per day, or daily visits beyond 14 consecutive days that have not been preauthorized.
23. Hospice care such as:
    - Any services or supplies not included in the hospice care plan, not specifically mentioned under "Hospice Care," or provided in excess of the specified limits.
    - Expenses for normal necessities of living such as food, clothing, or household supplies, Meals on Wheels, or similar services.
    - Homemaker, chore worker, or housekeeping services (except as provided by home health aides as part of the hospice program).
    - Legal or financial counseling.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Services provided while the enrollee is receiving home health care benefits.
    - Services to other than the terminally ill enrollee including bereavement, pastoral, or spiritual counseling.
    - Supportive environmental materials/ improvements (handrails, ramps, etc.).
24. Hospital inpatient charges such as:
    - Admissions solely for diagnostic purposes that could be performed on an outpatient basis.
    - Beds "reserved" while the patient is being treated in a special-care unit or is on leave from the hospital.
    - Personal items (television, special diets not medically necessary to treat the covered condition, or convenience items).
    - Private room charges, unless medically necessary and approved by the UMP.
25. Immunizations, except as described under "Preventive Care." Immunizations for the purpose of travel or employment are not covered.
26. Impotence treatment with medications or pharmaceuticals.
27. Infertility or sterility testing or treatment, such as artificial insemination or in vitro fertilization.

28. Learning disabilities treatment after diagnosis, including for dyslexia, except as described under "Neurodevelopmental Therapy."
29. Maintenance therapy (see definition of maintenance care).
30. Manipulations of the spine or extremities, except as described under "Spinal and Extremity Manipulations."
31. Marital, family, sexual, or other counseling or training services, except services provided by a UMP network licensed marriage and family therapist for neuropsychiatric, mental, or personality disorders.
32. Massage therapy, unless services meet the criteria in "Physical, Occupational, Speech, and Massage Therapy" under "Covered Expenses." Services from massage therapists who are not UMP network providers are not covered.
33. Mental, neuropsychiatric, or personality disorder treatment, except as described under "Mental Health Treatment."
34. Missed appointments, or completing or copying forms or records, except copying records to perform retrospective utilization review.
35. Non-network and out-of-network provider charges in excess of the plan's allowed charges.
36. Obesity treatment, including any medical services, drugs, supplies, or surgery such as gastroplasty, gastric stapling, or intestinal bypass.
37. Organ donor coverage for anyone who is not a UMP enrollee, or for locating a donor (such as tissue typing of family members), except as described under "Organ Transplants."
38. Organ transplants or related services in nondesignated facilities, or transportation or living expenses related to organ transplants. See "Plan Designated Facilities."
39. Orthoptic therapy (eye training) or vision services, except as described under "Vision Care (Routine)."
40. Over-the-counter drugs, except the following products when prescribed by an approved provider type licensed to prescribe drugs: insulin, prenatal vitamins, and nicotine replacement therapy (while participating in the Free and Clear tobacco cessation program).
41. Recreation therapy.
42. Replacement of lost or stolen medications.
43. Residential mental health treatment programs or care in a residential treatment facility.
44. Reversal of voluntary sterilization (vasectomy or tubal ligation).
45. Services or supplies to the extent benefits are *available* under any automobile medical, automobile no-fault, workers' compensation, personal injury protection, commercial liability, commercial premises medical, homeowner's policy, or other similar type of insurance or contract, if it covers medical treatment of injuries. (Benefits are considered *available* if you are a named insured, come within the definition of insured, or are a third-party beneficiary under the policy.) However, UMP payments will be advanced upon request if you agree to apply for benefits under the other insurance

or contract and to reimburse the UMP when settlement is received.

46. Services delivered by types of providers not listed as approved, or by providers delivering services of a type or in a manner not within the scope of their licenses.
47. Services of a non-network or out-of-network Licensed Master of Social Work, Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, or non-Ph.D. psychologist, except when employed by and delivering services within a community mental health agency and that agency bills for such services.
48. Services of an out-of-network or non-network massage therapist/practitioner.
49. Services or drugs related to tobacco use and smoking cessation, except as described under "Preventive Care" and "Tobacco Cessation" in "Covered Expenses."
50. Services or supplies:
    - For which no charge is made, or for which a charge would not have been made if you had no health care coverage.
    - Provided by a family member.
    - That are solely for comfort (except as described in "Hospice Care" in "Covered Expenses").
    - For which you are not obligated to pay.
51. Services or supplies obtained through a "private contract" agreement with a physician or practitioner who does not provide services through the Medicare program–when Medicare is the primary payer.
52. Services received outside of required case management when you are required to participate in and comply with a case management plan as a condition of continued benefit payment (see the *2003 Certificate of Coverage* for details and exceptions).
53. Sexual disorder, diagnosis, or treatment.
54. Sexual reassignment surgery, services, counseling, or supplies.
55. Skilled nursing facility services or confinement for:
    - Mental health conditions.
    - Mental retardation.
    - Primarily domiciliary, convalescent, or custodial care.
56. Surgical treatment to alter the refractive character of the cornea, such as radial keratotomy, photokeratectomy, or LASIK surgery.
57. Vitamins (except prenatal vitamins during pregnancy, when prescribed by an approved provider type licensed to prescribe drugs), minerals, or nutritional supplements.
58. Weight-loss drugs, services, or supplies.
59. Wilderness training programs for chemical dependency.

If you have questions about whether a certain service or supply is covered, call the UMP at 1-800-352-3968 or 425-670-3150 in the Seattle area. You can also find the *2003 UMP Certificate of Coverage* on the Web at www.ump.hca.wa.gov.

How the Dental Plans Work

To enroll in dental coverage, you must enroll in PEBB medical coverage. If you enroll in a dental plan, you must continue dental coverage for **at least two years**. You have three dental plans to choose from:

Preferred Provider Organization (PPO)

- **The *Uniform Dental Plan (UDP)***, administered by Washington Dental Service (WDS), allows you the freedom to choose any dentist, but provides a higher reimbursement if your dentist contracts with WDS. The UDP *offers services in every county of Washington State*. Outside of Washington, services are reimbursed at a higher level than for services provided by non-PPO dentists in Washington.

More information on Washington Dental Service

Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers several dental plans, including the Uniform Dental Plan (UDP) and DeltaCare. If you choose UDP or DeltaCare, be sure that you choose a WDS-contracting dentist who participates with your plan.

Managed Care Plans

- ***DeltaCare, administered by WDS,*** requires selection of one of their network dentists when you enroll. You must verify your dentist contracts with DeltaCare as WDS administers several types of dental plans, each with its own provider network. This is important, as you could be responsible for costs if you receive care from a provider who is not in the DeltaCare network. *Providers are located in* Arlington*, Auburn, Bellevue, Bremerton, Burien, Edmonds*, Everett, Federal Way, Kent, Lynnwood, Mill Creek, Mukilteo, Olympia, Puyallup, Redmond*, Renton, Seattle, Shelton, Spokane, Tacoma, Tukwila, Tumwater, Vancouver, Wenatchee, Yakima, and Portland (Oregon).

  ** Not accepting new patients.*

- ***Regence BlueShield Columbia Dental Plan,*** with services provided by Columbia Dental Group (CDG), requires that you receive care from CDG dentists. Their *clinics are located in* Bellevue, Bellingham, Everett, Federal Way, Kent, Kirkland, Lynnwood, Northgate, Olympia, Puyallup, Richland, Seattle, Silverdale, Spokane, Tacoma, Tri-Cities (Kennewick), Tumwater, Vancouver, and Yakima.

Please note: Since clinic participation with the dental plans can change, please contact the dental plans to verify clinic locations.

Dental Plans

Is a Managed-Care Dental Plan Right for You?

The table on the next page briefly compares the features of the UDP and the managed-care dental plans. Before enrolling in a managed-care dental plan, it is important to answer the following questions:

- Is the dentist I have chosen accepting new patients? (Remember to identify yourself as a PEBB state of Washington retiree.)
- Am I willing to travel for services if I select a dentist in another service area?
- Do I understand that all dental care is managed through my primary care dentist or network provider, and I cannot self-refer for specialty care?

If the answer to these questions is yes, you may want to consider enrolling in a managed-care dental plan.

For full coverage provisions, including a description of limitations and exclusions, refer to a PEBB certificate of coverage (available through the dental plans).

Please note: Benefits for emergency care received out of the plan's service area; missed appointment charges; and the number of exams, x-rays, cleanings, and other procedures allowed in a certain time period vary from plan to plan. Contact the plans directly for details. (Dental plan phone numbers are listed at the front of this guide.)

If you are receiving continuous dental treatment (such as orthodontia) and are considering changing plans, contact the plans directly to find out how they cover your continuous dental treatment if you enroll in their plan.

Dental Benefits Comparison

(For more details on benefits and exclusions, contact the plans.)

	Preferred provider organization: • *Uniform Dental Plan*	Managed-care dental plans: • *DeltaCare* • *Regence BlueShield Columbia Dental Plan*
Annual deductible	$50 per person/$150 per family, except for diagnostic and preventive	No deductible
Annual maximum	$1,500 plan reimbursement per person; except as otherwise specified for orthodontia, nonsurgical TMJ, and orthognathic surgery	No general maximum
Dentures	50%, PPO and out of state; 40%, non-PPO (dental plan payment)	$140 copay, complete upper; $40 copay, complete reline (chairside)
Endodontics (root canals)	80%, PPO and out of state; 70%, non-PPO (dental plan payment)	$50 copay, 1 canal; $125 copay, 4 canals
Nonsurgical TMJ	70%; $500 lifetime maximum (dental plan payment)	70%; $500 lifetime maximum (dental plan payment)
Oral surgery	80%, PPO and out of state; 70%, non-PPO (dental plan payment)	$0 copay, single extraction; $10 copay, each additional tooth **Exception:** *Regence*, $0 copay, each additional tooth
Orthodontia	50%; $750 lifetime maximum (dental plan payment)	$1,500 maximum copay per case **Exception:** *Regence*, $1,200 maximum copay per case
Orthognathic surgery	70%; $5,000 lifetime maximum (dental plan payment)	70%; $5,000 lifetime maximum (dental plan payment)
Periodontic services	80%, PPO and out of state; 70%, non-PPO (dental plan payment)	$75 copay, gingivectomy or gingivoplasty per quadrant; $100 copay, osseous surgery per quadrant
Preventive/ diagnostic	100%, PPO; 90%, out of state; 80%, non-PPO (dental plan payment)	100% (dental plan payment)
Restorative crowns	50%, PPO and out of state; 40%, non-PPO (dental plan payment)	$100 copay, resin base-metal crown **Exceptions:** *DeltaCare*, $175 copay, full or ¾ cast metal crown; *Regence*, $140 copay, full or ¾ cast metal crown
Restorative fillings	80%, PPO and out of state; 70%, non-PPO (dental plan payment)	$10 copay, amalgam restorations (fillings), permanent teeth, two surfaces **Exception:** *Regence*, $0 copay

UDP and Regence Dental General Exclusions

The following services are not covered:

1. Dentistry for cosmetic reasons. Cosmetic services include, but are not limited to, laminates, veneers, or tooth bleaching.
2. Restorations or appliances necessary to increase or alter the vertical dimension or to restore the occlusion. Excluded procedures include restoration of tooth structure lost from attrition (Uniform Dental Plan [UDP] only), and restorations for abrasion, erosion, or malalignment of teeth.
3. Application of desensitizing medicaments.
4. Services or supplies that the plan determines are experimental or investigative. Determination is made according to the following criteria. If any of these situations are met, the service or supply is considered experimental and/or investigative, and benefits will not be provided.
    a. It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA), and such approval has not been granted on the date it is furnished.
    b. The provider has not demonstrated proficiency in the service, based on experience, outcome, or volume of cases.
    c. Reliable evidence shows the service is the subject of ongoing clinical trials to determine its safety or effectiveness.
    d. Reliable evidence has shown the service is not as safe or effective for a particular dental condition compared to other generally available services and that it poses a significant risk to the enrollee's health or safety.

    Reliable evidence means only published reports and articles in authoritative dental and scientific literature, scientific results of the provider's written protocols, or scientific data from another provider studying the same service.

    The documentation used to establish the plan's criteria will be made available for your examination at the office of the plan if you send a written request.

    If the plan determines that a service is experimental or investigative, and therefore not covered, you may appeal the decision. The plan will respond in writing within 20 working days after receipt of a claim or other fully documented request for benefits, or a fully documented appeal. The 20-day period may be extended only with your informed written consent.
5. Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient management drugs, such as pre-medication and nitrous oxide.
6. General anesthesia, including intravenous and inhalation sedation, except that coverage will be provided for general anesthesia services in conjunction with any covered dental procedure performed in a dental office if such anesthesia services are medically necessary because the enrollee is under the age of 7, or physically or developmentally disabled (except for UDP only when in conjunction with covered oral

surgery, endodontic, and periodontal surgical procedures).

7. Hospital or other facility care for dental procedures, including physician services and additional fees charged by the dentist for hospital treatment. However, this exclusion will not apply and benefits will be provided for services rendered during such hospital care, including outpatient charges, if all these requirements are met:
    a. A hospital setting for the dental care must be medically necessary.
    b. Expenses for such care are not covered under the enrollee's employer-sponsored medical plan.
    c. Prior to hospitalization, a request for preauthorization of dental treatment performed at a hospital is submitted to and approved by the plan. Such request for preauthorization must be accompanied by a physician's statement of medical necessity.

    If hospital or facility care is approved, available benefits will be provided at the same percentage rate as those performed by a participating dental provider, up to the available benefit maximum.
8. Dental services started prior to the date the person became eligible for services under this plan, except as provided for orthodontic benefits.
9. Services for accidental injury to natural teeth when evaluation of treatment and development of treatment plan is performed more that 30 days from the date of the accident.
10. Expenses incurred after termination of coverage, except expenses for:
    a. Prosthetic devices that are fitted and ordered prior to termination and delivered within 30 days after termination.
    b. Crowns, if the tooth is prepared prior to termination and the crown is seated on the tooth within 30 days after termination.
    c. Root canal treatment, if the tooth canal is opened prior to termination and treatment is completed within 30 days after termination.
11. Missed appointments.
12. Completing insurance forms or reports, or for providing records.
13. Habit-breaking appliances, except as specified under the orthodontia benefit.
14. Full-mouth reconstruction (Regence Dental also excludes dental implants).
15. Charges for dental services performed by anyone who is not a licensed denturist (Regence Dental only), dentist, or physician, as specified.
16. Services or supplies that are not listed as covered.
17. Treatment of congenital deformity or malformations.
18. Orthodontic treatment, orthognathic treatment, and treatment of temporo-mandibular joint (TMJ) disorders that are not authorized in advance by the plan.

19. Replacement of lost or broken dentures or other appliances.
20. Services for which an enrollee has contractual rights to recover cost, whether a claim is asserted or not, under automobile, medical, personal injury protection, homeowner's, or other no-fault insurance.
21. In the event a UDP enrollee fails to obtain a required examination from a UDP (Washington Dental Service)-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment (UDP only).
22. UDP (Washington Dental Service) shall have the discretionary authority to determine whether services are covered benefits in accordance with the general limitations and exclusions shown in the contract, but it shall not exercise this authority arbitrarily or capriciously or in violation of the provisions of the contract (UDP only).

DeltaCare
General Exclusions

1. General anesthesia, including intravenous and inhalation sedation, and the services of a special anesthesiologist, except that coverage will be provided for general anesthesia services in conjunction with any covered dental procedure performed in a dental office if such anesthesia services are medically necessary because the enrollee is under the age of 7, or physically or developmentally disabled.
2. Cosmetic dental care. Cosmetic services include, but are not limited to, laminates, veneers, or tooth bleaching.
3. Services for injuries or conditions which are compensable under Worker's Compensation or Employers' Liability laws, and services which are provided to the eligible person by any federal, state, or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
4. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such procedures include restoration of tooth structure lost from attrition, abrasion, or erosion without sensitivity and restorations for malalignment of teeth.
5. Application of desensitizing agents.

6. Experimental services or supplies. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DeltaCare (WDS), in conjunction with the American Dental Association, shall consider if: (1) the services are in general use in the dental community in the state of Washington; (2) the services are under continued scientific testing and research; (3) the services show a demonstrable benefit for a particular dental condition; and (4) they are proven to be safe and effective. Any individual whose claim is denied due to this experimental exclusion clause shall be notified of the denial within 20 working days of receipt of a fully documented request. Any denial of benefits by DeltaCare (WDS) on the grounds that a given procedure is deemed experimental, may be appealed to DeltaCare (WDS).
7. Dental services performed in a hospital and related hospital fees.
8. Loss or theft of fixed or removable prosthetics (crowns, bridges, full or partial dentures).
9. Dental expenses incurred in connection with any dental procedure started after termination of eligibility of coverage.
10. Dental expenses incurred in connection with any dental procedure started prior to the enrollee's eligibility, except for orthodontic services.
11. Cysts and malignancies.
12. Laboratory examination of tissue specimen.
13. Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient management drugs, such as pre-medication and nitrous oxide.
14. Cases which in the professional judgment of the attending dentist a satisfactory result cannot be obtained or where the prognosis is poor or guarded.
15. Prophylactic removal of impactions (asymptomatic, nonpathological).
16. Specialist consultations for non-covered benefits.
17. Implant placement or removal; however, crowns placed on implants will be covered.
18. Orthodontic treatment which involves therapy for myofunctional problems, TMJ dysfunctions, micrognathia, macroglossia, cleft palate, or hormonal imbalances causing growth and developmental abnormalities.
19. All other services not specifically included on the patient's copayment schedule as a covered dental benefit.
20. Treatment of fractures and dislocations to the jaw.
21. Correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function (unless mandated by state law).
22. Dental services received from any dental office other than the assigned dental office, unless expressly authorized in writing by DeltaCare (WDS) or as cited under "Out of Area Emergency Treatment" in DeltaCare's certificate of coverage.

Appendix A:

Selecting the Best Plan for You and Your Family & Medical Benefits Comparison

Selecting the Best Medical Plan for You and Your Family

All medical plans, with the exception of Medicare Supplement Plans E and J, offer the same basic benefits, although benefit enhancements, limitations, premiums, and out-of-pocket maximums may vary. For example, all plans offer a smoking cessation program, but each plan's program is different. Only you can decide which plan makes the most sense for you and your family. Keep the following in mind: If you cover eligible dependents, they must be covered under the same medical/dental plans you choose. If you and your spouse/qualified same-sex domestic partner are both on Medicare Parts A and B, you must enroll in the same plan; if only one of you is eligible to enroll in a Medicare supplement plan and chooses Plan E or J, the spouse (or other family member) who is not eligible for Medicare must enroll in the Uniform Medical Plan (UMP). Retirees or their family members on Medicare disability are also eligible for coverage under PEBB-sponsored Medicare supplement plans.

As you review the plans, here are some things to consider:

- **Geography.** In most cases, you must live in the plan's service area to join the plan. Refer to "Plans Available by County" to find out which plans are available to you.
- **Cost.** As a retiree, you pay for your medical or medical/dental coverage. Keep in mind, higher cost doesn't necessarily mean higher quality of care or higher benefits; each plan has the same basic level of benefits.
- **Unique medical needs.** If you or a family member need certain medical care, you may want to choose a plan that provides the optimum benefits and coverage for the needed treatment, medications, or equipment. Please note: Each plan has a different formulary, which is a list of approved prescription drugs that the plan will cover.
- **Coinsurance vs. copays.** Managed-care plans described in this guide require you to pay a fixed portion (called a "copay" or "copayment") at the time you receive network care. Under the UMP, the enrollee is responsible for a coinsurance (percentage of an allowed fee). A coinsurance is also applied to extended network managed-care benefits in addition to the copay.
- **Deductible.** The UMP requires that an annual medical/surgical and prescription drug deductible be paid before the plan begins reimbursing for covered services. (Preventive care and certain other benefits are exempt from the UMP deductibles.) The extended network managed-care plan also has an annual deductible when you receive care from an extended network provider.
- **Out-of-pocket maximum.** This is the maximum amount you pay in one calendar year. Once you have paid this amount, most plans pay 100 percent of allowed charges for most covered services for the remainder of the calendar year. The out-of-pocket maximum varies. For a list of expenses that apply to the out-of-pocket maximum, see the definition of annual out-of-pocket maximum in the "Glossary."
- **Referral procedures.** Some plans allow you to self-refer to any network provider; others require that you have a referral from your primary care provider. Self-referral to a participating provider for women's health care services is a requirement of all plans.
- **Your provider.** If you have a long-term relationship with your doctor or health care provider, you may want to find out whether (s)he is a primary care provider in the plan's network before you join.
- **Paperwork.** In general, the plans don't require you to file claims. However, you may need to if you select the extended network managed-care plan and see an extended-network provider, or if you enroll in the UMP and see a non-network provider.
- **Coordination with your other benefits**. See "Coordination of Benefits" on page 12 for more information.

Questions? Contact the medical plans directly (phone numbers are listed at the front of this guide).

Want more help in making a medical plan choice?

Go to the PEBB's Web site at **www.pebb.hca.wa.gov** and use the Compare-a-Plan tool and Provider Directory.

Medical Benefits Comparison

The following table briefly compares the network benefits for the Uniform Medical Plan (UMP) in Washington and Oregon, and in-network benefits for PEBB managed-care plans. Call the plans directly for more information on specific benefits or exclusions.

Benefits for:	Annual deductible	Annual out-of-pocket maximum	Office, clinic, & hospital visits	Ambulance (air)	Ambulance (ground)	Chemical dependency services (inpatient)
Standard managed-care plans: *Group Health Cooperative of Puget Sound* *Kaiser Foundation Health Plan of the Northwest* *PacifiCare of Washington, Inc.* *Premera Blue Cross/ Foundation** *RegenceCare* **Extended network managed-care plan (only in-network benefits described):** *Group Health Options, Inc.* **Please note:** Some extended network benefits are subject to an annual deductible. Please contact the extended network plan for details.	None	$750 per person/ $1,500 per family for network benefits	$10 copay per office/ clinic visit; hospital visits covered in full	$100 copay per trip Exception: *Kaiser Permanente*, $75 copay per trip	$75 copay per trip	Subject to inpatient hospital services copay; maximum plan payment of $11,285 in any 24-month period for any combination of inpatient/ outpatient treatment
	These plans offer a Medicare+Choice plan for retirees 65 or older. For a description of Medicare+Choice plans, see page 11. Generally speaking, the Medicare+Choice benefits are comparable or superior to managed-care plan benefits. Please refer to the certificates of coverage for each Medicare+Choice plan for specific benefits.					
Preferred provider organization: *Uniform Medical Plan* **Please note:** For **non-Medicare retirees**, the UMP pays 80% of allowed charges for most covered services by network providers outside of Washington and Oregon, and where network providers are not available. The UMP pays 60% of allowed charges for nonnetwork providers when a network provider is available. Contact UMP for details. **For Medicare retirees:** The UMP pays 80% of allowed charges for most covered services outside of Washington and Oregon. *For Medicare Supplement Plan E and Plan J benefits, see Appendix C.	Medical/ surgical services: $200 per person/$600 per family (three or more people) Prescription drug (retail and mail-order): $100 per person/$300 per family (three or more people)	Medical/ surgical services: $1,125 per person/ $2,250 per family (Does not apply to prescription drugs, non-network provider services, and other expenses as defined in the certificate of coverage)	90% reimburse-ment	80% of allowed charges reimburse-ment	80% of allowed charges reimburse-ment	Subject to inpatient hospital services copay; maximum plan payment of $11,285 in any 24-month period for any combination of inpatient/ outpatient treatment

Chemical dependency services (outpatient)	Diabetic education	Diagnostic testing	Durable medical equipment, supplies, and prostheses	Emergency room services	Hearing (examination & hardware)	Home health care	Hospice care (including respite care)	Inpatient hospital services
Subject to office visit copay; maximum plan payment of $11,285 in any 24-month period for any combination of inpatient/ outpatient treatment	$10 copay per visit	100%	80% of allowed charges	$75 copay per visit; emergency room copay waived if admitted to hospital inpatient status	Examination: Subject to office visit copay Hardware: $300 maximum plan payment every 36 consecutive months for hearing aid and rental/ repair when authorized	100%	100% for terminally ill enrollees	$200 copay per day to $600 maximum copay per person per calendar year
90% reimbursement; maximum plan payment of $11,285 in any 24-month period for any combination of inpatient/ outpatient treatment	90% reimburse-ment	90% reimburse-ment	90% reimbursement; preauthorization required for equipment rentals beyond three months or purchases more than $1,000	$75 copay per visit, then reimbursed at 90%; copay waived if admitted to hospital inpatient status	90% reimburse-ment up to $400 every 36 months for exams, hearing aid, and rental/ repair combined	90% reimburse-ment	If pre-approved by plan, 100% reimburse-ment; $5,000 lifetime maximum for respite care	$200 copay per day to $600 maximum copay per person per year

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Benefits for:	Mental health care (inpatient)	Mental health care (outpatient)	Organ transplants	Outpatient surgery, ambulatory surgery centers	Physical, occupational, speech, & massage therapy (inpatient)	Physical, occupational, speech, & massage therapy (outpatient)
Standard managed-care plans: *Group Health Cooperative of Puget Sound* *Kaiser Foundation Health Plan of the Northwest* *PacifiCare of Washington, Inc.* *Premera Blue Cross/ Foundation** *RegenceCare* **Extended network managed-care plan (only in-network benefits described):** *Group Health Options, Inc.* **Please note:** Some extended network benefits are subject to an annual deductible. Please contact the extended network plan for details.	$200 copay per day to $600 maximum copay per person per calendar year; plan payment limit up to 10 days per year (For more information, contact the plans.)	$10 copay per office/ clinic visit, up to 20 visits per year	Facility: Subject to inpatient hospital services copay Professional services: 100% Bone marrow donor searches covered in full up to 15 searches per person per transplant	$100 copay for facility fees per surgery or procedure (includes short-stay obstetrical services); surgeon, anesthesiologist, etc., paid in full	Subject to inpatient hospital services copay to 60 days per year	Subject to office visit copay to 60 visits per year for all therapies combined
Preferred provider organization: *Uniform Medical Plan* **Please note:** For **non-Medicare retirees**, the UMP pays 80% of allowed charges for most covered services by network providers outside of Washington and Oregon, and where network providers are not available. The UMP pays 60% of allowed charges for nonnetwork providers when a network provider is available. Contact UMP for details. **For Medicare retirees:** The UMP pays 80% of allowed charges for most covered services outside of Washington and Oregon. *For Medicare Supplement Plan E and Plan J benefits, see Appendix C.	$200 copay per day to $600 maximum copay per person per calendar year; plan payment limit up to 10 days per year	90% reimbursement per office/ clinic visit, up to 20 visits per year	Hospital inpatient: Subject to inpatient hospital services copay; preauthorization required Professional services: 90% reimbursement; preauthorization required Bone marrow donor searches reimbursed at 90% up to 15 searches per person per transplant	90% reimbursement	Subject to inpatient hospital services copay to 60 days per calendar year; preauthorization required	90% reimbursement, up to a total of 60 visits per calendar year for all therapies combined (also includes massage therapy; massage therapists must be UMP network providers)

Prescription drugs, insulin, and disposable diabetic supplies	Preventive care	Radiation & chemotherapy services	Skilled nursing facility care	Spinal manipulations (self-referred)	Temporo-mandibular joint (TMJ) disorder	Vision (examination)	Vision (hardware)
Retail (up to a month's supply): Formulary generic, all insulin, and all disposable diabetic supplies, $10 copay; formulary brand-name, $25 copay; non-formulary, $40 copay **Mail-order** (up to 90-day supply): Formulary generic, all insulin, and all disposable diabetic supplies, $20 copay; formulary brand-name, $50 copay; non-formulary, $80 copay **Exceptions:** *Group Health Cooperative* and *Group Health Options* have only $10 and $30 copays for retail, and $20 and $40 copays for mail order. *Kaiser Permanente* has only $10 and $25 copays for retail, and $20 and $50 copays for mail order.	100%, subject to plan schedule	100%	Subject to inpatient hospital services copay; limited to 150 days per year, except if in lieu of hospital-ization	50%, up to $250 maximum per year **Exception:** *Premera Blue Cross* pays 100%, subject to $10 copay per visit	Inpatient and outpatient surgical treatment paid at 50% to $1,000 maximum plan payment per year; orthognathic surgery not covered	Subject to office visit copay; one exam every 24 consecutive months	$50 maximum plan payment once every 24 consecutive months
Up to 90-day supply, UMP formulary (subject to prescription drug deductible) **Retail:** Tier 1 (generic, all insulin, and all disposable diabetic supplies), 80% reimbursement*; Tier 2 (formulary single-source brand), 70% reimbursement*; Tier 3 (non-formulary single-source brand and all multi-source brand), 50% reimbursement **Tier 1 and 2 drugs purchased through a network retail pharmacy have a maximum enrollee cost-share of $50 (up to a 30-day supply), $100 (31- to 60-day supply), and $150 (61- to 90-day supply)* **Mail order:** Tier 1, $10 copay**; Tier 2, $40 copay**; Tier 3, $80 copay** ***or cost of drug, whichever is less*	100%, subject to plan schedule (not subject to medical/ surgical deductible)	90% reimburse-ment	Subject to inpatient hospital services copay; limited to 150 days per calendar year, except if in lieu of hospital-ization	90% reimburse-ment to 10 visits per year	Surgical treatment covered same as any other condition; 90% reimbursement when preauthorized; orthognathic surgery not covered	90% reimburse-ment once every two calendar years (not subject to medical/ surgical deductible)	$100 maximum plan payment every two calendar years for frames, lenses, contacts, and fitting fees combined (not subject to medical/ surgical deductible)

Appendix B:

Glossary

Glossary

Allowed charges
The maximum amount that your insurance plan will pay for covered services, treatments, or supplies.

Annual deductible
The amount you must pay each calendar year before the plan pays benefits for covered expenses. Most plans described in this guide do not have an annual deductible, except for the UMP and Group Health Options' extended network benefits. Some benefits may not apply to the annual deductible. Refer to your plan's certificate of coverage for details.

Annual out-of-pocket maximum
The most you would pay toward the majority of covered expenses in a calendar year. This means once you've reached your out-of-pocket maximum, most plans pay 100 percent of most covered expenses for the rest of the calendar year. These expenses apply to the out-of-pocket maximum:

- Inpatient hospital admissions
- Ambulance service
- Outpatient/day surgery and ambulatory surgery centers
- Physical, occupational, speech, and massage therapy
- Organ transplants
- Skilled nursing facility services

Group Health Options' extended network benefits and UMP benefits usually have different out-of-pocket limits from standard managed-care benefits. Refer to your plan's certificate of coverage for details.

Certificate of coverage
A legal document that describes eligibility, covered services, limitations and exclusions, utilization procedures, and other plan provisions. The medical or dental plan will provide you with a certificate of coverage once you are enrolled.

Coinsurance
The percentage you pay on claims for which your plan pays benefits at less than 100 percent.

Copays
The fixed cost you pay for services at the time you receive care. Most plans described in this guide require copays (sometimes called "copayments") when you see network providers or receive prescription drugs.

Drug formulary
A list of approved prescription drugs that the plan will cover. Each plan has a different formulary. Contact the plans for details.

Glossary

Emergency
Conditions with symptoms so severe that most people would reasonably expect that, without immediate health care attention, the condition would:

- Seriously jeopardize the individual's physical or mental health
- Seriously impair bodily functions
- Cause a serious dysfunction of any body organ or part

Your plan reserves the right to determine whether the symptoms indicate a medical emergency. See the plan's certificate of coverage for details.

Extended network
Enrollees in Group Health Options may choose from the Group Health provider network, or an extended network of providers. Extended network providers are outside of the Group Health network, but agree to provide services to Group Health Options' enrollees at negotiated rates. Enrollees are allowed to self-refer to extended network providers for covered services, but may have to pay an annual deductible and will receive a lower reimbursement from the plan.

HCA
The Health Care Authority (HCA) is a state agency that develops and administers health insurance programs for state and higher-education employees, retirees, and their dependents, as well as other eligible groups who choose to purchase PEBB coverage. The HCA provides medical, dental, life, and long-term disability insurance coverage to eligible enrollees through the Public Employees Benefits Board (PEBB). PEBB enrollees receive their benefits through private health plans that contract with the Health Care Authority and the self-insured Uniform Medical Plan and Uniform Dental Plan. The PEBB is responsible for designing and approving benefits plans and eligibility provisions for public employees, retirees, and their dependents, in accordance with state and federal laws.

Hospice care
Medical, therapeutic, nursing, or counseling services for a terminally ill patient and family enrollees by a public or private agency or organization for that specific service.

Inpatient
A patient who is admitted for an overnight or longer stay at a health care facility and is receiving covered services.

Maximum plan payment for medical plans
The total amount paid out by each PEBB-sponsored medical plan, except Medicare supplement plans, on behalf of each covered individual for all benefits, is limited to a lifetime maximum plan payment of $1,000,000. Up to $10,000 of the lifetime maximum is restored automatically each January 1 for benefits paid by the plan during the prior calendar year. Some services are also subject to specific calendar year or lifetime benefit limitations, as detailed in each plan's certificate of coverage.

Midyear
Any time other than the open enrollment period.

Network
A group of health care providers in a certain geographic location (including doctors, hospitals, and other health care professionals and facilities) who agree to provide services to a health plan's members at negotiated rates.

Open enrollment period
The period of time each year during which you may change medical and/or dental plans, and add family members to your coverage without providing proof of previous coverage.

Outpatient
A patient who has not been admitted but is receiving covered services inside or outside a health care facility under a provider's direction.

Premium
The amount PEBB enrollees pay monthly for the cost of their health insurance. Premiums vary in cost depending on the health plan and the number of family members covered.

Primary care provider (PCP)
The doctor or nurse you choose to see for regular office visits, and who may refer you to and coordinate your care with specialists.

Some PEBB managed-care plans require each enrollee to have a primary care provider, who may be in family practice, internal medicine, or pediatrics. For some plans, women may also choose obstetricians or gynecologists for their PCP. However, each covered family member may have a different PCP. If you do not choose a PCP, some plans will choose one for you based on where you live. You may change your PCP during the year. The list of providers may be updated periodically.

Provider
A health care practitioner or facility operating within the scope of a license.

Specialist
A provider of specialized medicine, such as a cardiologist or a neurosurgeon.

Subnetwork
A provider group (such as hospitals, physicians, specialists, and other providers) whose providers may restrict your choice of referred specialists to only those within that same provider group.

Appendix C:

Outline of Medicare Supplement Coverage

Appendix D:

Monthly PEBB Retiree Rates

Appendix E:

Adding a Spouse/Same-Sex Domestic Partner to Your PEBB Coverage

Adding a Spouse/Same-Sex Domestic Partner to Your PEBB Coverage

Washington State Health Care Authority
Public Employees Benefits Board

Important! Complete the form in this packet and return with a completed PEBB enrollment form.

Complete and return the form in this packet if you want to:

- Add a spouse to your Public Employees Benefits Board (PEBB) coverage, or
- Add a qualified same-sex domestic partner to your PEBB coverage.

Adding a Spouse

Remove the form from this packet.

Step One:

- Read through the declaration. You only need to fill out side A of the form.

Step Two:

- Print your names and the **date of your marriage** in the spaces at the top of the form.
- Sign, date, and provide your social security numbers at the bottom of the form.

Step Three:

- **Employees**: Return the form to your personnel, payroll, or benefits office.
- **All others**: Return the form to the Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684.

Adding a Same-Sex Domestic Partner

Remove the form from this packet.

Step One:

- Review the declaration form; be sure you meet the 10 criteria for a same-sex domestic partnership.
- Print your names in the spaces at the top of the form.
- Sign, date, and provide your social security numbers at the bottom of the form.

Step Two (for **active employees** and **Medicare retirees** only):

- Review the *Declaration of Tax Status* form (side B).
- Determine whether your same-sex domestic partner fulfills the three requirements listed for Internal Revenue Code (IRC) Section 152 tax eligibility. **Your same-sex domestic partner does not need to qualify as an IRC Section 152 dependent to qualify for PEBB coverage.**
- Print your and your same-sex domestic partner's names at the top of the form.
- If you are unsure whether your same-sex domestic partner qualifies as an IRC Section 152 dependent, you may confirm eligibility by using the IRC *Worksheet for Determining Dependent Status* form. Go to Step Three.
- If your same-sex domestic partner qualifies as an IRC Section 152 dependent, go to Step Four.

Step Three:

- If completing the optional *Worksheet for Determining Dependent Status*, you and your same-sex domestic partner will need to know your:
  - Gross monthly income
  - Mortgage/rental payment
  - Monthly expenses for items such as food, utilities, repairs, clothing, education, medical, travel, etc.
- Keep the worksheet for your personal tax records. You do not need to return the worksheet with the other forms.

Step Four:

- Sign, date, and print your social security number on the *Declaration of Tax Status* form.
- **Employees**: Return the forms to your personnel, payroll, or benefits office.
- **All others**: Return the forms to the Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684.

Worksheet for Determining Dependent Status

(Worksheet modeled after the IRC worksheet in Publication 17)

☞ Do **not** return this form; keep for your own tax records.

Important

You can use this worksheet to determine whether your same-sex domestic partner and/or his or her child(ren) qualify as dependents under Internal Revenue Code (IRC) Section 152 (in general, he or she must receive more than half of his or her support from you).

Income

1. Did the same-sex domestic partner you supported receive any income such as wages, interest dividends, pensions, rents, social security, or welfare?
   - ❑ Yes (Answer questions 2, 3, 4, and 5.)
   - ❑ No (Skip to question 6.)
2. Total annual income received $ _____
3. Amount of income used for your same-sex domestic partner's support $ _____
4. Amount of income used for purposes other than support $ _____
5. Amount of income either saved or not used for lines 3 or 4 $ _____

The total of lines 3, 4, and 5 should equal line 2.

Yearly household expenses where you and your same-sex domestic partner lived

6. Lodging (*Complete either a or b):*
   a. Rent paid $ _____
   b. If not rented, show fair rental value of your home $ _____
   If your same-sex domestic partner owned the home, include this amount on Line 20.
7. Food $ _____
8. Utilities (heat, light, water, etc. not included in line 6a or 6b) $ _____
9. Repairs that were not included in line 6a or 6b $ _____
10. Other (i.e., furniture). Do not include expenses of maintaining home (i.e., mortgage interest, real estate taxes, and insurance). $ _____
11. Add lines 6a or 6b through 10 $ _____
12. Total number of persons who lived in household _____

Yearly expenses for your same-sex domestic partner

13. Divide line 11 by line 12 to determine each person's part of household expenses

    $ _____ (line 11) ÷ _____ (line 12) = $ _____ (line 13)

14. Clothing $ _____
15. Education $ _____
16. Medical and dental $ _____
17. Travel and recreation $ _____
18. Other (please specify) _____ $ _____
    _____ $ _____
    _____ $ _____
19. Total amount for your same-sex domestic partner's yearly support (Add lines 13 through 18) $ _____

20. Amount your same-sex domestic partner provided for his or her own support

    Line 3 $ _____

    Line 6b (include if your same-sex domestic partner owned the home) $ _____

    Add lines 3 and 6b, if each are applicable $ _____ line 20

21. Amount that others added to your same-sex domestic partner's support. Include amounts provided by state, local, and other welfare societies or agencies. Do not include any amounts included on line 2. $ _____

22. Amount **you** provided for your same-sex domestic partner's support:

    $ _____ (line 20) + $ _____ (line 21) - $ _____ (line 19) = $ _____ (line 22)

23. 50% of line 19 $ _____

If line 22 is more than line 23, your same-sex domestic partner qualifies as an IRC Section 152 dependent. Check "Yes" on the *Declaration of Tax Status* form.

If line 22 is **not** more than line 23, check "No" on the *Declaration of Tax Status* form. As a result, the amount that **the state will contribute** (shown below) for your qualified same-sex domestic partner and/or child(ren) is considered taxable by the IRS. The tables below show the amount that will be added to your total gross income and calculated into your withholding tax; this will be reflected on your pay stub, as well as your *Wage and Tax Statement* (your W-2). The monthly amounts below are rounded to the nearest dollar, consistent with IRS tax reporting.

Active employees

	2003 State Contribution for Medical and Dental Coverage for:		
Medical Plan	**Partner**	**Partner's Child(ren)**	**Partner and Child(ren)**
Community Health Plan	$276	$223	$499
All other medical plans	$285	$230	$515

	2003 State Contribution for Dental Coverage (Without Medical Coverage) for:		
Dental Plan	**Partner**	**Partner's Child(ren)**	**Partner and Child(ren)**
All dental plans	$33	$33	$66

Medicare retirees

Medical Plan	**2003 State Contribution for Medical Coverage for Partner**
Premera BC Medicare Supplement Plan E	$46
PacifiCare	$79
Kaiser Permanente	$84
All other medical plans	$93

Health plan comparisons in this document are based on information believed accurate and current, but be sure to confirm data before making decisions.

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

Declaration of Marriage

Washington State Health Care Authority
Public Employees Benefits Board

E

I, _____, certify that
Print Subscriber's Name

_____ and I were legally married on _____/_____/_____
Print Spouse's Name month / day / year

- OR -

Declaration of Same-Sex Domestic Partnership

_____ and I established a same-sex domestic partnership beginning
Print Same-Sex Domestic Partner's Name

_____/_____/_____ and we meet the following criteria for a same-sex domestic partnership:
month / day / year

1. We have been same-sex domestic partners continuously for a minimum of six months.
2. We share the same regular and permanent residence.
3. We have a close personal relationship in lieu of a lawful marriage.
4. We have agreed to be jointly responsible for basic living expenses[1], as defined below, incurred during the domestic partnership.
5. We are not married to anyone.
6. We are each eighteen (18) years of age or older.
7. We are not related by blood as close as would bar marriage.
8. We were mentally competent to consent to a contract when the domestic partnership began.
9. We are each other's sole domestic partner and are responsible for each other's common welfare.
10. We are same-sex partners who are barred from a lawful marriage.

[1] "Basic living expenses" means the cost of basic food, shelter, and any other expenses of the common household. You and your same-sex domestic partner need not contribute equally or jointly to the payment of these expenses as long as it is agreed that both are responsible for them. If requested, you should be able to provide at least three of the following as verification of your joint responsibility (information should be dated to confirm eligibility at time of enrollment):

- Joint mortgage or lease.
- Designation of the same-sex domestic partner as primary beneficiary for a life insurance or a retirement contract.
- Designation of the same-sex domestic partner as primary beneficiary in the employee/covered member's will.
- Durable power of attorney for health care or financial management.
- Joint ownership of a motor vehicle, a joint checking account, or a joint credit account.
- A relationship or cohabitation contract which obligates each of the parties to provide support.

Subscribers are advised to consult an attorney regarding the possibility that the filing of this declaration may have other legal and/or financial consequences, including the fact that it may, in the event of the termination of the domestic partnership, be regarded as a factor leading a court to treat the relationship as the equivalent of marriage for the purposes of establishing and dividing community property, assigning community debt, and for the payment of support.

It is understood that:

- This declaration shall be terminated upon death of the spouse or same-sex domestic partner or by change of circumstance attested to in this declaration.
- Employees will notify their personnel, payroll, or benefits office and retirees and Consolidated Omnibus Budget Reconciliation Act (COBRA)/self-pay members will notify the Health Care Authority at 1-800-200-1004 if the marriage has dissolved or the domestic partnership no longer meets all of the criteria attested to in this declaration within thirty-one (31) days of a change.

We declare, under penalty of perjury, that the foregoing information provided by us is true and correct and that all provisions of this statement have been met. Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

_____	_____ - _____ - _____	_____
Subscriber's Signature	Social Security Number	Date
_____	_____ - _____ - _____	_____
Spouse or Same-Sex Domestic Partner's Signature	Social Security Number	Date

Agency use only	Agency	Subagency

Declaration of Tax Status

I, _____, have completed a *Declaration of Marriage/Same-Sex Domestic Partnership*
Print Subscriber's Name

form and have sworn that _____ is my same-sex domestic partner. I understand
Print Same-Sex Domestic Partner's Name

that my employer has a legitimate need to know the federal income tax status of my relationship. I understand that a same-sex domestic partner is considered an Internal Revenue Code (IRC) Section 152 dependent **only if each** of the following requirements is met (does **not** affect your same-sex domestic partner's eligibility for PEBB coverage):

1. The same-sex domestic partner and I live together (share our principal abode) for the full taxable year, except for temporary absences for reasons such as vacation, military service, or education. In other words, my same-sex domestic partner and I must live together from January 1 through December 31.
2. The same-sex domestic partner is a citizen or resident of the United States.
3. The same-sex domestic partner receives more than half of his or her support from me. The rules for determining support are complicated and are more involved than just determining who is the "primary breadwinner." Attached is a worksheet similar to one the Internal Revenue Service (IRS) includes in its Publication 17 that you can use to determine whether you provide more than half of your same-sex domestic partner's support.

Please Note:

Even if the above requirements are met, an individual cannot be considered an IRC Section 152 dependent if the relationship violates local law.

Check one of the following boxes; **coverage is only available** if you check a box. Since the above is a summary of complex tax rules, we recommend you consult with your tax advisor regarding your specific circumstances. I declare that:

- ❑ **Yes**, my same-sex domestic partner **is** my Internal Revenue Code Section 152 dependent.
- ❑ **No**, my same-sex domestic partner is **not** my Internal Revenue Code Section 152 dependent. As a result, premium contributions for my same-sex domestic partner cannot be taken on a pre-tax basis (under IRC Section 125), and the fair market value of the benefits my employer provides for my partner will be added to my taxable income.
- ❑ **Yes**, my same-sex domestic partner's child(ren) **is** my Internal Revenue Code Section 152 dependent(s).
- ❑ **No**, my same-sex domestic partner's child(ren) is **not** my Internal Revenue Code Section 152 dependent(s). As a result, premium contributions for my same-sex domestic partner's eligible family members cannot be taken on a pre-tax basis (under IRC Section 125), and the fair market value of the benefits my employer provides for my partner will be added to my taxable income.

By signing below, you are stating that:

I understand that this information will be held confidential and will be subject to disclosure only upon my express written authorization or if otherwise required by law. I understand that this declaration of responsibility may have legal implications under federal and/or state law. I understand that a civil action may be brought against me for any losses, including reasonable attorney's fees, because of a false statement contained in this *Declaration of Tax Status*. I also certify under penalty of perjury, under the laws of the state of Washington, that the foregoing is true and correct.

I, the undersigned subscriber, understand that willful falsification of information on this declaration may lead to disciplinary action, up to and including discharge from employment and/or disenrollment from PEBB coverage. I agree to notify my personnel, payroll, or benefits office or the Health Care Authority at 1-800-200-1004 if there is any change in the circumstances attested to in this declaration within thirty-one (31) days of the change. *I am aware that any change in my family tax status may directly impact the calculation of my taxable income.*

Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

_____	_____ - _____ - _____	_____
Subscriber's Signature	Social Security Number	Date

Appendix F:

Forms

Completing the Medical and Dental Coverage Forms

(Please use black ink to complete the form[s].)

Step 1:

Check the "Plans Available by County" section in this guide to find out which plans are available to you.

Step 2:

If you're changing dental plans, or adding family members to your coverage, fill out Form A. If you're adding a spouse or qualified same-sex domestic partner to your coverage, you will also need to complete the *Declaration of Marriage/Same-Sex Domestic Partnership* form, available in Appendix E.

If you're selecting a medical plan, locate your 2003 plan choice in the columns below:

- **Medical plans 1-5 –** Fill out Form A.
- **Medical plans 6-8 –** Fill out Forms A and C.
- **Medical plans 9-10 –** Fill out Forms A and B.

Important! If you or any covered dependents haven't sent in a copy of your Medicare card(s), please send a copy of it along with the form(s).

Step 3:

Be sure to include all eligible family members you wish to enroll. Complete, sign, and date the form(s) before mailing to:

Washington State
Health Care Authority
P.O. Box 42684
Olympia, WA 98504-2684

Please feel free to call 1-800-200-1004 and choose option 3 to speak with a representative if you have questions about the enrollment process.

Step 4:

You'll receive a letter from the Public Employees Benefits Board (PEBB) program, confirming your plan change. Keep that letter! When you receive medical services or pick up a prescription drug from your pharmacy after January 1, 2003, the letter may serve as your member identification (I.D.) card until you receive your new medical/dental plan I.D. card.

Please note: The Uniform Dental Plan does not issue I.D. cards.

Please note:
If you're adding a qualified same-sex domestic partner to your coverage and completing Form B or C, same-sex domestic partners need to use the "spouse" sections.

Form A	Forms A and C	Forms A and B
1. Group Health Cooperative of Puget Sound	6. Group Health Cooperative Medicare+Choice	9. Medicare Supplement Plan E*
2. Group Health Options, Inc.	7. Kaiser Senior Advantage	10. Medicare Supplement Plan J*
3. Premera Blue Cross	8. PacifiCare Secure Horizons	
4. RegenceCare		
5. Uniform Medical Plan		

**Administered by Premera Blue Cross*

STATEMENT OF UNDERSTANDING

I understand that beginning on my effective date with the Medicare+Choice plan I have selected on the reverse of this form, all medical services, with the exception of emergency, or out-of-area urgently needed services, must be provided or arranged for by the plan. Services rendered without prior authorization of my Medicare+Choice contracting primary care physician (PCP) will not be reimbursed by the plan or Medicare, except for emergency services anywhere in the world or urgently needed services outside the plan's service area (or under unusual and extraordinary circumstances, provided when I am in the service area, but my contracting medical group is temporarily unavailable or inaccessible).

I understand that I can be a member of only one Medicare+Choice coordinated care plan at any time. By enrolling in the Medicare+Choice plan I have selected, I will automatically be disenrolled by the Health Care Financing Administration (HCFA) from any other Medicare+Choice coordinated care plan of which I may be a member.

By enrolling in the Medicare+Choice plan, I authorize the Health Care Financing Administration to provide information to the Medicare+Choice plan I select confirming my entitlement for Medicare Hospital Insurance Benefits (Part A) and to Supplementary Medical Insurance Benefits (Part B) under Title XVIII (the Medicare Program) of the Social Security Act. I understand that I must maintain my Medicare Part A and Part B insurance by continuing to pay the Part B premiums and the Part A premiums, if applicable. I also authorize the Medicare+Choice plan's provider or any other holder of medical or other relevant information about me to release to HCFA or HCFA's agents any information needed to administer Title XVIII of the Social Security Act.

I HEREBY AUTHORIZE any person including–but not limited to–physicians, hospitals, insurance companies and other organizations to release any information acquired by such person in the course of examination or treatment of myself, which is relevant to the provision of or coordination of benefits or the professional review activities.

I understand that it is my responsibility to inform the Medicare+Choice plan I have selected prior to either permanently moving out of the service area or leaving the service area for more than twelve (12) months, and that my absence means the plan must disenroll me and return me to the original Medicare coverage.

I understand that I may disenroll from this Medicare+Choice plan by sending a written request to the Medicare+Choice plan I have selected, the Social Security Office, or the Railroad Retirement Board. Until confirmation of the effective date of disenrollment, I must continue to receive health care from the Medicare+Choice plan providers.

I understand that as a member of the Medicare+Choice plan, I have the right to appeal service and payment denials made by the plan.

I understand that my enrollment in the Medicare+Choice plan I have selected is effective with my date of retirement or January 1, if enrolling during the Public Employees Benefits Board (PEBB) annual open enrollment period. I understand that upon confirmation from HCFA, the Medicare+Choice plan will send me written notice of my effective date. As of my enrollment effective date, all of my routine health care must be provided for by plan-contracting medical providers.

Note: Until you have received this written notification, you should not drop any supplemental insurance you have in effect now.

This form represents your temporary Medicare+Choice plan identification card. Until you receive your Medicare+Choice identification card, please keep it with you and present it each time you require services from a contracted provider. Whenever possible, the Medicare+Choice organization provides the member, prior to the effective date, evidence of health insurance coverage so that (s)he may begin using the plan services as of the effective date.

Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at www.pebb.hca.wa.gov.

Washington State Health Care Authority
Public Employees Benefits Board

Medicare+Choice Plan Election Form

Please fill in all information requested. Be sure to read the back of this form.

C

Retiree/Spouse Information

Social Security Number	Last Name (as appears on Medicare card) First Name Middle Initial	Home Phone ( )
Permanent Residential Address	❑ Male ❑ Female / Date of Birth (Mo/Day/Yr) / /	(Mo/Day/Yr) ❑ Married / /
City State ZIP Code +4	County (Residence)	Medical/Dental Effective Date (Mo/Day/Yr)
Mailing Address (if different than above) City State ZIP Code +4		County (Residence)

Relationship **SPOUSE**	Last Name First Name Middle Initial	Social Security Number	Date of Birth (Mo/Day/Yr) / /
Permanent Residential or Mailing Address (if different from above)	City	State	ZIP Code +4

Medicare

Retiree

Retiree Name _____

Medicare Claim Number _____-_____-_____-_____

Is entitled to Effective Date Effective Date

Hospital (Part A) / / Medical (Part B) / /

Spouse

Spouse Name _____

Medicare Claim Number _____-_____-_____-_____

Is entitled to Effective Date Effective Date

Hospital (Part A) / / Medical (Part B) / /

PCP and Plan Choice

I wish to cancel my current medical coverage: ❑ Yes ❑ No

I wish to enroll in/change medical plans as indicated:

❑ Group Health Cooperative ❑ Kaiser Senior Advantage ❑ PacifiCare Secure Horizons

I wish to cancel my current dental coverage: ❑ Yes ❑ No

I wish to enroll in/change dental plans as indicated:

❑ DeltaCare–Dentist or clinic code _____

❑ Regence BlueShield Columbia Dental Plan–Clinic location _____

❑ Uniform Dental Plan

Retiree

Name of Contracting Primary Care Physician (PCP) (refer to Provider Directory) _____

Are you a current patient? ❑ Yes ❑ No

Spouse

Name of Contracting Primary Care Physician (refer to Provider Directory) _____

Are you a current patient? ❑ Yes ❑ No

Medical Information

1. **Do you currently have end-stage renal disease (kidney disease)?** Retiree: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No
   If yes, are you currently a member of PacifiCare of Oregon/ Washington? Retiree: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No
2. **Do you have any health insurance other than Medicare?**
   Retiree: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No
   If yes, through which company? _____
   What type of policy? _____
   Do you intend to discontinue this policy?
   Retiree: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

Note: Your answers to questions #3 and #4 below will **not** affect your eligibility to enroll in a Medicare+Choice plan.

3. **Do you live in an institution?**
   Retiree: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No
   If yes, name of institution _____
   Address _____
   Phone number _____
   Date of admission _____
4. **Are you currently receiving Medicaid?** Retiree: ❑ Yes ❑ No
   Spouse: ❑ Yes ❑ No If yes, Medicaid #: _____

Signature and Authorization

I authorize Department of Retirement Systems to deduct from my retirement allowance the amount required to pay for this coverage. ❑ Yes ❑ No

I certify that to the best of my knowledge and belief, my dependents and I are eligible for the coverage requested. I understand that if I enroll in dental coverage, I must maintain dental coverage for at least two years. This supersedes all forms I have previously submitted for Public Employees Benefits Board coverage. A premium deposit does not guarantee coverage and will be refunded if I am determined to be ineligible for coverage.

My signature below warrants that I have read and understand this Medicare+Choice Plan Election Form, including the Statement of Understanding on the back of this form, and that the information provided by me is accurate and complete. Please refer to the Medicare+Choice plan's Evidence of Coverage document for a written copy of the rules you must follow in order to receive coverage under this Medicare+Choice plan contract. A copy of your selected Medicare+Choice Evidence of Coverage document will be sent to you upon receipt of your enrollment by the plan.

_____ _____

Signature of Applicant (see Privacy Notice on back) Date Signature of Spouse Date

_____ _____

Signature of individual who assisted the applicant and/or spouse in completing this form Date Relationship to Applicant/Spouse

❑ If Durable Power of Attorney for Health Care (DPAHC) for applicant and/or spouse, indicate here and attach certificate or other written proof of legal guardianship.

HCA 51-576 (10/02)

Return to: Washington State Health Care Authority; PO Box 42684; Olympia, WA 98504-2684

Washington State Health Care Authority (HCA)
Plan E and J Eligibility Requirements

Public Employees Benefit Board (PEBB) and K-12 Retirees

To be eligible, you must be either an eligible PEBB or K-12 retiree or the eligible spouse of such a retiree. You must also be covered by Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare. Application must be made:

- In the 30-day period before you become eligible for Parts A and B of Medicare;
- Within 60 days of retirement;
- Within six months of initial enrollment in Medicare Part B;
- Within six months after attaining age 65; or
- During an open enrollment period, if any, established by HCA for PEBB and K-12 retirees, providing that you are enrolling from another health plan with no lapse in coverage.

Existing PEBB and K-1 2 subscribers may change their coverage by applying for another program offered by the HCA only at the HCA's next open enrollment period for PEBB and K-12 retirees.

All Other Applicants

To be eligible, you must be a current Washington State resident. You must also be covered by Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare.
Application must be made:

- Within 60 days of establishing Washington State residency;
- In the 30-day period before you become eligible for Parts A and B of Medicare;
- Within 60 days of retirement;
- Within six months of initial enrollment in Medicare Part B;
- Within six months after attaining age 65; or
- During an open enrollment period, if any, established by HCA for persons who are **not** PEBB or K-12 retirees, providing that you are enrolling from another health plan with no lapse in coverage.

Additional Application Periods for All Eligible Applicants

You can also apply for the HCA Plan E or J coverage if:

1. You left the HCA Plan E or J to try a Medicare+Choice program, PACE program, or Medicare Cost, Risk, or Select program for the first time. You may apply if you tried one program, more than one program of the same type, or more than one type of program. However, all four statements below must be true:

   - You were covered under each program you tried for less than 12 months
   - Each program (other than the most recent) must have been terminated involuntarily.
   - You switched programs within 63 days of the date the prior program terminated, with no other coverage inbetween.
   - The effective date of the last program you tried was less than 24 months after the effective date of the first program you tried.

2. If you are applying for the HCA Plan E or J offered only to people who have Medicare by reason of age, you can also apply if, at age 65 and first becoming eligible for Medicare Part A, you enrolled in one or more Medicare+Choice or PACE programs. All four statements in 1. must also be true.
   You must give us proof that you had and lost the coverage as described above. If you qualify for coverage under 1. or 2. above, you must apply no earlier than 60 days before your prior coverage is to end and no later than 63 days after that coverage ended. **Note: If you qualify under 1. above, you may only apply for the HCA Medicare supplement plan you had orginally.**

PREMERA | BLUE CROSS

Washington State Health Care Authority
Medicare Supplement Enrollment Form

B

Applicant	Spouse
Social Security Number ☐☐☐-☐☐-☐☐☐☐	Social Security Number ☐☐☐-☐☐-☐☐☐☐
Applicant Last Name First Name Initial	**Spouse Last Name** First Name Initial
Mailing Address	Mailing Address
City State Zip	City State Zip
County / Phone Number ( )	County / Phone Number ( )
Date of Birth month day year / Sex ☐ Male ☐ Female	Date of Birth month day year / Sex ☐ Male ☐ Female
Medicare effective dates: Part A month day year / Part B month day year	Medicare effective dates: Part A month day year / Part B month day year
Medicare Claim Number (refer to your Medicare card)	Medicare Claim Number (refer to your Medicare card)

Medicare Supplement Plan desired ☐ Plan E ☐ Plan J

Please read the statements and answer the questions below.

A. You do not need more than one Medicare supplement contract.

B. If you purchase this coverage, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

C. If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement contract.

D. The benefits and premiums under your Medicare supplement contract can be suspended if requested during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your contract will be reinstituted if requested within 90 days of losing Medicaid eligibility.

E. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement coverage and concerning medical assistance through the state Medicaid program, including benefits as a "Qualified Medicare Beneficiary" (QMB) and a "Specified Low-Income Medicare Beneficiary" (SLMB).

To the best of your knowledge,

1. Do you have another Medicare supplement policy or certificate in force? Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No
   a) If so, with which company? _____
   b) If so, do you intend to replace your current Medicare supplemental policy with this coverage?
   Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No
   (If you do not intend to replace all other Medicare supplement coverage, you are not eligible to apply for this program.)

2. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement coverage?
   Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No
   a) If so, with which company? _____
   b) What kind of policy? _____

3. Are you covered for medical assistance through the state Medicaid program:
   a) As a "Specified Low-income Medicare Beneficiary" (SLMB)? Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No
   b) As a "Qualified Medicare Beneficiary" (QMB)? Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No
   c) For other Medicaid medical benefits? Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No
   (If you are covered by Medicaid, you are not eligible to apply for this program.)

4. Did you receive a copy of the Outline of Coverage? ☐ Yes ☐ No

5. Would you like to receive a copy of the "Guide to Health Insurance for People with Medicare"? ☐ Yes ☐ No

I hereby apply for the Premera Blue Cross Group Medicare Supplement Plan, and agree to the terms of the contract offered. I understand that I must meet the applicable eligibility requirements, and apply within the time limits,that are shown on the back of this form. I hereby authorize the Social Security Administration to furnish to Premera Blue Cross medical or other information acquired by it under the Medicare Program to the extent necessary to process any claim under the contract in effect with Premera Blue Cross. This authorization is in effect for the duration of my coverage with Premera Blue Cross. I certify that the foregoing statements and answers are true, and I understand that all rights to payment of medical claims by Premera Blue Cross are void if any statement made by me herein is found to be false or incomplete.

X _____ Date
Applicant Signature

X _____ Date
Spouse Signature

65-8216(4-2002)
An Independent Licensee of the Blue Cross Blue Shield Association

SECTION 3: Additions or Changes
(Check all that apply.)

Retiree changed: ❑ Name ❑ Address ❑ Medical plan ❑ Dental plan

Change in family status:

❑ **Adding a spouse or same-sex domestic partner.**
You **must** complete a Declaration, available from the Health Care Authority or online at www.pebb.hca.wa.gov

❑ **Adding family member A**

❑ **Adding family member B**

SECTION 4: Medical Plan Selection
(Check only one.)

❑ Group Health Cooperative of Puget Sound

❑ Group Health Options, Inc.

❑ Kaiser Foundation Health Plan of the Northwest

❑ PacifiCare of Washington, Inc.*

❑ Premera Blue Cross

❑ RegenceCare*

❑ Uniform Medical Plan

❑ Medicare Supplement Plan E, administered by Premera Blue Cross

❑ Medicare Supplement Plan J, administered by Premera Blue Cross

** These plans require the physician or clinic code of your selected primary care provider. Contact plan for code.*

SECTION 5: Dental Plan Selection
(Check only one.)

Preferred Provider Organization
(may receive services *from any provider*):

❑ Uniform Dental Plan (Group #3000)

Managed Care Plans

❑ DeltaCare (Group #3100)
Dentist name_____
(must receive services from *DeltaCare provider*)

❑ Regence BlueShield Columbia Dental Plan
Clinic location_____
(must receive services from *Columbia Dental Group provider*)

Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

SECTION 7: Life Insurance Enrollment Information

Retiree Term Life Insurance is **only available** to those who received PEBB coverage as an active employee. Application for Retiree Term Life Insurance must be made at the time of retirement.

I hereby elect to enroll in the PEBB Retiree Term Life Insurance Plan. ❑ **Yes** ❑ **No**

Disabled retirees who qualify for the waiver of premium benefit under the PEBB employee life insurance plan are not eligible for this Retiree Term Life Insurance Plan.

Age at Time of Death	Amount of Insurance in Force at Time of Death
Under 65	$3,000
65 through 69	$2,100
70 and over	$1,800

Beneficiary _____

Beneficiary's SSN_____ Relationship to retiree_____

Address_____

_____

SECTION 6: Waive or Terminate Coverage

Waiving medical coverage:

❑ **Self** (includes all family members)
I understand that proof of continuous, comprehensive, employer-provided medical coverage will be required to re-enroll in a PEBB medical plan. Application for reenrollment must be made within 60 days of the date I lose other coverage.

❑ **Spouse or same-sex domestic partner**

❑ **Other family member(s)** ❑ A ❑ B
I understand that proof of continuous, comprehensive medical coverage will be required to reenroll family members in a PEBB plan outside of an open enrollment period. If I die, my eligible dependent(s) must enroll in or waive PEBB coverage (due to enrollment in comprehensive employer-provided medical coverage) within 60 days of my death.

Cancelling dental coverage:

❑ **Self and all other family members**
I understand I must have maintained dental coverage for at least two years before I can cancel dental coverage for myself and all enrolled family members.

Terminating medical and dental coverage:

❑ **Self and all other family members**
I understand that I am forfeiting all further rights to reenroll in the PEBB program.

❑ **Other family member(s)**

Reason: ❑ **Widowed** ❑ **Divorce** Date of event_____
❑ **Other**_____

Name_____

Address_____

_____

I certify that I have read and understand the provisions above for waiving or terminating PEBB coverage.

_____
Retiree's signature Date

_____
When do you want the coverage to end? (mm/dd/yyyy)

SECTION 8: Authorization for Enrollment and/or Premium Deduction

I authorize the Department of Retirement Systems to deduct from my retirement allowance the amount I am required to pay for this coverage. ❑ **Yes** ❑ **No**

I certify that, to the best of my knowledge and belief, my family members and I are eligible for the coverage requested. **I understand that if I enroll in dental coverage, I must maintain dental coverage for at least two years**. This supersedes all forms I have previously submitted for Public Employees Benefits Board coverage. A premium deposit does not guarantee coverage and will be refunded if I am determined to be ineligible for coverage.

Washington State law may require disclosure of any information I submit as a public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

_____
Retiree's signature Date

Washington State Health Care Authority
Public Employees Benefits Board

Be sure to sign and date this form.

Return form to: Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684

Public Employees Benefits Board (PEBB)

2003 Retiree Medical and Dental Coverage

A

- List all family members you wish to enroll on this form.
- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- Dependents must be enrolled in the same plans as the retiree, except as specified for Medicare Supplement Plans E and J.

Retirement system name	**Retirement date** (mm/dd/yyyy)

For K-12 school district retirees only:

When does your current school district medical/dental coverage end? (mm/dd/yyyy)	School district

SECTION 1: Retiree Information

Social security number	Sex ❑ M ❑ F	Last name	First name	Middle initial

Address

City	State	ZIP Code	County of residence

Date of birth (mm/dd/yyyy)	Work phone number (including area code)	Home phone number (including area code)

The medical plans marked with an asterisk (*) in Section 4 assign a physician or clinic code to their providers and require you to choose a primary care provider. **Contact your plan or go to the Provider Directory on our Web site for code.**

Physician or clinic code

Are you or your spouse or same-sex domestic partner enrolled in both Parts A and B of Medicare?

Retiree ❑ Yes ❑ No

Spouse or same-sex domestic partner ❑ Yes ❑ No

Are you or your spouse or same-sex domestic partner on Medicare disability?

Retiree ❑ Yes ❑ No

Spouse or same-sex domestic partner ❑ Yes ❑ No

Note: *If you or your dependents are Medicare eligible, you must be enrolled in Medicare Parts A and B. If you haven't sent in a copy of your Medicare card(s), please send a copy of it along with this form.*

SECTION 2: Family Member Information

*List **only** family members you wish to cover; family members **cannot** be enrolled in any other PEBB coverage.*

Relationship to retiree

If enrolling a spouse/partner, please attach a completed *Declaration of Marriage/Same-Sex Domestic Partnership* form.

❑ **Spouse:** date of marriage _____

❑ **Same-sex domestic partner:** date criteria met _____

Social security number	Sex ❑ M ❑ F	Physician or clinic code (contact plan for code)

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Other Family Members (such as child, grandchild, etc.) ***Use additional forms for more members***

A **Relationship to retiree**

❑ Disabled? ❑ Student? *(Check only if age 20 or older)*

Sex ❑ M ❑ F

Social security number	Physician or clinic code (contact your plan for code)

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Address (if different from retiree)	City	State	ZIP Code

B **Relationship to retiree**

❑ Disabled? ❑ Student? *(Check only if age 20 or older)*

Sex ❑ M ❑ F

Social security number	Physician or clinic code (contact your plan for code)

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Address (if different from retiree)	City	State	ZIP Code